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Middlesex University
Drug and Alcohol Research Centre

Identifying promising approaches and initiatives to reducing alcohol related harm

Report to Alcohol Research UK and the
Joseph Rowntree Foundation

Rachel Herring, Mariana Bayley, Anthony Thickett,
Katie Stone and Seta Waller.



2011

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List of abbreviations

AERC – Alcohol and Education Research Council

AIP- Alcohol Improvement Programme -

ALC- Alcohol Learning Centre

ARCAP – Auckland Regional Community Action Project

BAC – Blood Alcohol Content

CAP – Community Alcohol Partnership

CMDA – Complying with the Minimum Drinking Age project

COMPARI – Community Mobilisation for the Prevention of Alcohol Related Injury

CPI – Centre for Public Innovation

CSP – Community Safety Partnership

CTIRHRD - Community Trials Intervention To Reduce High-Risk Drinking

DAAT – Drug and Alcohol Action Team

DH – Department of Health

ERIC - Education Resources Information Center

EU – European Union

HIC- High Impact Change

HImP – Health Improvement Programme

HubCAPP – Hub of Commissioned Alcohol Projects and Policies

IBA – Identification and Brief Advice

IBBS - Institute of Biomedical and Biomolecular Science

JASAP – Juvenile and Adolescent Substance Abuse Prevention Program

KCAP – Kent Community Alcohol Partnerships

LWA – Living With Alcohol project

MCP – Multiple Component Programme

NI – National Indicator

PAKKA – Local Alcohol Policy project (Finland)

PCT – Primary Care Trust

RASG – Retail of Alcohol Standards Group

RBS – Responsible Beverage Service

RTA – Road Traffic Accident

SEAIP- South East Alcohol Improvement Programme

SHAHRP – School Health and Alcohol Harm Reduction Project

STAD – Stockholm Prevents Alcohol and Drug Problems)

YATA – Youth Access to Alcohol

1. Introduction

1.1 Background

The consumption of alcohol is an integral part of the lives of many people living in the UK and is embedded in a variety of social practices. Whilst drinking alcohol is, for the most part, a pleasurable experience associated with relaxation and celebrations, there are a number of societal and health harms associated with its consumption. These wide ranging harms include alcohol related disorders and diseases, crime, violence, unemployment and absenteeism; in 2003 they were estimated to cost £18-25 billion a year (Prime Ministers Strategy Unit, 2004), whilst in 2007 the National Social Marketing Centre produced a much higher estimate of £55.1 billion (Lister, 2007). The cost of the harmful use of alcohol (regularly drinking at increasing or higher risk levels) to the NHS in England has been estimated to be around £2.7 billion (Department of Health, 2008a). The need to find effective ways of reducing alcohol related harm in the UK is thus high on the policy and political agenda.

Box 1: The High Impact Changes:

1. Work in partnership
2. Develop activities to control the impact of alcohol misuse in the community
3. Influence through advocacy
4. Improve the effectiveness and capacity of specialist treatment
5. Appoint an Alcohol Health Worker
6. Identification and Brief Advice (IBA) – Promote more help to encourage people to drink less
7. Amplify national social marketing priorities

Since the 1990s the UK government has placed increasing emphasis on developing and implementing policy that is evidence based. For example, the *New NHS* White Paper stated that “services and treatments that patients receive across the NHS should be based on the best evidence of what

does and does not work and what provides best value for money” (Department of Health, 1997, paragraph 75), or put simply ‘what counts is what works’. More recently, the Department of Health (DH) identified seven ‘evidence based’ ‘High Impact Changes’ ¹(HICs) (see Box 1) for alcohol which were calculated to have the greatest impact on health

¹High Impacts Changes have been used across the NHS and local government to highlight practical measures that can be implemented at local level (Department of Health, 2009, p. 73).

outcomes, in particular in reducing the rate of alcohol related hospital admissions ² (Department of Health, 2009). Guidance on how to implement the HICs was contained in *Signs for Improvement: commissioning interventions to reduce alcohol-related harm* (Department of Health, 2009). The guidance set out the rationale for each HIC, the evidence “that shows it is worth doing” (p. 74) and gave ‘case study’ examples to show how it had already been successfully implemented in local areas.

However, despite the prominence given to the need for policy and practice to be evidence based, in reality, getting research into policy and practice has proved to be far from straightforward. Similarly, attempting to implement evidence based practice ‘on the ground’ has faced a number of challenges, with the result that “it takes nine years, on average for interventions recommended as evidence based practices in systematic reviews, guidelines, or textbooks to be fully implemented” (Green *et al*, 2009, p.157). Within this study we hoped to be able to look at the nature of available evidence, the criteria which informs practice ‘on the ground’, and to establish the forms of evidence used by practitioners to judge the success of their initiatives.

1.2 Aims and Methods

The research aimed to identify promising approaches that could be included in multi-component programmes (MCP) to reduce alcohol related harm at local level. This study was underpinned by the recognition that the voices of practitioners are often marginalised in the debates about ‘what works’ and it set out to include their views. So whilst acknowledging the importance of the international research literature, we took care not to privilege it over other ‘softer’ sources e.g. knowledge and experience of practitioners.

Objectives

1. Using three key sources (published international research literature; grey literature from the UK ; the knowledge of stakeholders involved in developing and delivering local alcohol policy and interventions) to develop criteria to judge the ‘promise’ of initiatives;
2. Using these criteria identify and provide descriptions of ‘promising’ initiatives which have been implemented in the UK;

As the study progressed it became apparent that the multi component approach was only one of several ‘models’ that seem to have salience in providing a particular framework for those working to reduce alcohol related harm at a local level. Other models which appear to

²The reduction of alcohol related hospital admissions was the national indicator (NI 39) linked to the Public Service Agreement (PSA 25) aimed at reducing the harm caused by drugs and alcohol which covered the period 2008/09 – 2010/11.

have influenced the developments of recently emerging 'promising' initiatives are the 'partnership' approach and the 'innovation' approach. While international literature on MCPs remained the main body of research literature consulted, the research was modified in response to these emergent findings.

What was also evident was the impact of the inclusion -for the first time- of an alcohol harm-related target in the performance framework for local authorities and local authority partnerships for the period 2008/9-2010/11. The Public Service Agreement (PSA 25) stated: 'the reduction of the harm caused by alcohol and drugs' as the target (HM Government, 2007a). The National Indicator 39³ (NI 39) was used to measure progress on this target: NI 39 measured the rate of alcohol related admissions per 100,000 population using Hospital Episode Statistics (HES) (HM Government, 2008) and the aim was to 'reduce the trend in the increase of alcohol related hospital admissions' (HM Government, 2007b, p.67). Many of the promising initiatives identified within this study were explicitly aimed at NI 39.

This study was conducted during a period of political upheaval, with the election of May 2010 heralding the end of new Labour's 13 years in office and the arrival of the Coalition Government. The ensuing review of policies, reorganisation of services and cuts to public services may mean the end of some of the initiatives identified within this study

Methods

Published literature review

The original research question was firmly located within a multi-component programme framework and so our literature review focused on the MCP literature. However, as the fieldwork progressed it became evident that the MCP approach was only one of several 'models' or implementation structures and collaborations within which practitioners are currently working that have credence for those working within the current policy landscape. Other models which appear to have influenced the developments of recently emerging 'promising' initiatives are the 'partnership' approach and the 'innovation' approach. It is important to note that these 'models' are not mutually exclusive, indeed there is some overlap, particularly between the MCP and partnership approaches. Whilst it was beyond the remit of this study to consider the literature on the other two models at any depth, to enable us to understand the key concepts that underpin these two models a focused examination of the literature was undertaken. A recent study involving three of the researchers who conducted the study (Bayley, Herring and Waller) investigated the role of partnership working as a mechanism for local alcohol policy implementation (Thom *et al*, 2011) and the learning from that study proved to be invaluable for the current research. Both partnership and innovation approaches are outlined in Chapter 6.

³ NI 39 was introduced in 2008 and the definition of the indicator was revised in April 2009.

This study was framed within a multi-component programme framework and a comprehensive narrative review was conducted of the MCP literature, using systematic review methodology of primary studies and reviews from the UK and international reviews. Studies published since 2000 in the English language were included. As much of the material was unlikely to meet quantitative Cochrane review standards it was based on qualitative approaches (Pope *et al*, 2007). The following databases were searched: the International Bibliography of Social Sciences (IBSS), Medline, PubMed, Web of Knowledge, ERIC (Education Resources Information Center), (see Appendix 1 for further details). An advanced search strategy was used together with 'snowballing techniques', chain searching (i.e. reference list follow-up), and web searches for relevant studies and organisations. For the international literature we also drew on reviews e.g. Stead *et al*, 2009; Babor *et al*, 2010; Thom and Bayley, 2007. Appendix 1 provides a full account of the screening used to identify relevant MCPs. In summary, 32 articles discussing and evaluating the effectiveness of 29 MCP interventions in the English language were identified and these form the basis of the MCP literature review. Criteria used in previous work evaluating multi-component approaches (Thom and Bayley, 2007) were employed, namely: type of population targeted, outcome measures, findings and authors' conclusions to assess a project's success.

Grey literature review

A review of the UK grey literature and unpublished interventions was conducted. The primary source of knowledge was the Hub of Commissioned Alcohol Projects and Policies (HubCAPP) resource (<http://www.hubcapp.org.uk/>), a web based resource of local initiatives (referred to on HubCAPP as 'projects') in England (Welsh projects were later included) hosted by Alcohol Concern and the Department of Health. HubCAPP was launched in 2008 and in September 2010, (during the course of the research) it was announced that HubCAPP would be integrated into the Alcohol Learning Centre (ALC), the DH online 'one-stop-shop' for alcohol matters (see <http://www.alcohollearningcentre.org.uk/Topics/projects/>). For the purposes of this research we used the information collected by the HubCAPP team based at Alcohol Concern. The initiatives that HubCAPP had information on were mainly health initiatives but also included education, enforcement, prevention, social marketing and other projects. HubCAPP had been informed of over 300 projects but very little information was available for most of them. There were 169 projects 'live' on the HubCAPP site prior to its transfer. These 169 projects formed the main resource for the grey literature review. In addition searches were conducted of the Kings Fund Library database and Social Care Online.

Scoping exercise

In thinking about what shows 'promise' we wanted to take into account the views and knowledge of people working in the field rather than just what has been identified by academics. We also wanted to gain a better understanding of what was happening 'on the

ground', so we conducted a scoping exercise. We were not aiming for a representative sample, but we did attempt to gather information from across the UK.

Initial scoping

The first step was to send out a short questionnaire by email to key informants working in the UK (i.e. alcohol leads, alcohol co-ordinators, substance misuse co-ordinators). We knew from an earlier study on partnership working in England (Thom *et al*, 2011) that such key informants have a variety of job titles and are located in different organisations (e.g. may be part of Drug and Alcohol Action Team (DAAT), Primary Care Trust (PCT), Community Safety Partnership (CSP), local authority etc) and thus a degree of 'detective' work would be required to identify them. We employed a number of strategies to identify potential respondents, including using known contacts from a recent study, contacts lists available online (e.g. for the Northern Ireland Drug and Alcohol Co-ordination teams, the Alcohol and Drug Partnerships in Scotland), following leads e.g. about projects featured on the ALC, HubCAPP, Home Office and by 'snowballing' (asking informants to suggest other potential respondents). We knew from previous experience that the contacts lists can often be out of date (which proved to be the case again) but with perseverance we were usually able to identify an appropriate contact for the area.

In Wales we contacted the 22 CSPs⁴ in Wales, the four Drug and Alcohol Co-ordination teams in Northern Ireland and the 30 Alcohol and Drug Partnerships in Scotland⁵. In England we contacted 97 key informants (located in PCT, DAATs, CSPs etc).

The questionnaire asked the respondents to identify the key alcohol related issues for their local area and to identify any examples of up to three projects or initiatives that they considered to be promising or innovative that were being used or had been used to tackle alcohol related harms in their area. Respondents were asked to include only those initiatives that were being (or had been) tried for the first time in their area; however, the initiative could have been implemented elsewhere. Telephone follow up was used to boost response rate. We received information about 72 initiatives from thirty respondents.

Follow-up interviews

We then conducted follow up telephone interviews to elicit further information about selected initiatives, including origins, evidence based aims, sources of funding, time scale of project, its focus (e.g. health, criminal justice etc), any adaptations, evaluation and sustainability of the initiative.

⁴There is a CSP for each of the 22 local authorities and substance misuse falls under their remit.

⁵ The Alcohol and Drug Partnerships replaced Alcohol and Drug Action Teams in 2009.

The initiatives were classified according to the categories shown in Table 1 below. The categories which emerged broadly reflect the 'High Impact Change' (HIC) interventions advocated within the DH's Alcohol Improvement Programme (AIP). To these we added a number of further categories to capture the diversity of responses obtained: a category of interventions targeted specifically at young people; information-sharing interventions; arrest referral schemes / interventions in criminal justice settings; education (including awareness-raising); other miscellaneous initiatives.

In deciding which projects to follow up, initiatives within each category were examined by the researchers and included if they were considered 'innovative', or rejected for one of two reasons. Those we followed up needed to fulfil at least one of the following criteria:

- to demonstrate a new approach at reducing alcohol related harm, either in its development and/or delivery to an at-risk group whose needs had to-date remained unaddressed;
- to adapt an existing approach to a novel setting;
- to identify a novel approach or process to enhance the development or delivery of an intervention.

One reason for rejecting initiatives was to avoid duplicating information about projects posted on HubCAPP which were already being examined within the 'grey literature' as part of our research. Secondly, initiatives identified as innovative in a particular locality but known by researchers to have been implemented elsewhere, or more widely, were rejected. On this basis interventions such as 'night buses', violent crime reduction interventions and young people's specialist drug and alcohol services were rejected as being extensively implemented. Similarly, 'High Impact Change' interventions, for example, Intervention and Brief Advice (IBA) in primary care settings, known to have become mainstream practice, were rejected; however, IBA interventions in novel settings were included. So, for example, alcohol arrest referral schemes targeting adult drinkers were not included but an innovative project in a prison setting offering support from an alcohol worker on release was deemed 'innovative'. From the 72 original interventions submitted we were able to select 26 initiatives for follow up. Information was collected from 19 respondents with some providing information about more than one initiative.

Table 1: Classification of initiatives

Initiatives:	TOTAL
Young people	4
Support and treatment of problematic drinkers/care planning	5
Information sharing	2
IBA in settings other than primary care	4
Town centre/night time economy	1

Arrest referral schemes/criminal justice	2
Education (including awareness-raising	1
Social marketing	1
Other	6
TOTAL	26

Workshop

In addition, we held a workshop in November 2010 which brought together an invited group of practitioners working in the alcohol field, with the aim of drawing on the expertise and knowledge of key stakeholders to help develop criteria for identifying 'promise' and in particular to look beyond the published literature to think about what 'works'. Participants included professionals with experience of working at local level (e.g. local authority) and also those who advise local level organisations (local authorities, PCTs etc) on how to address alcohol related issues in their locality. Participants shared their experiences and insights, provided practical examples of 'promising' initiatives, in groups designed MCPs in response to a scenario provided by the research team and explored key questions around sustainability, transferability and the development and implementation of new approaches.

1.3 Structure of the report

Chapter 2 examines the evidence from the broad international research literature and discusses the nature of evidence and how particular kinds of evidence are privileged which can lead to underplay the value of 'real world' experiences. A multi-component approach has emerged as a useful framework for designing local strategies to address alcohol related harm: Chapter 3 considers promising initiatives emerging from different typologies of multi-component programmes and presents an example of a pilot MCP, identified on the Alcohol Focus, Scotland website, at <http://www.alcohol-focus-scotland.org.uk/>. Innovative approaches identified in the field are outlined in Chapter 4 and alternative models for considering and developing promising approaches are discussed in Chapters 5 and 6. Chapter 5 discusses a partnership approach and illustrates this with a case study, Community Alcohol Partnerships. Chapter 6 examines an 'innovation' model as a means to generate and develop promising approaches. Two case studies, Frequent Flyers and Identification and Brief Advice are provided as examples. Finally, principles and key lessons for considering promising approaches are outlined in the conclusions.

2. Reducing alcohol related harm: what 'works'?

This chapter considers the evidence of what works from two different perspectives:

- The work of commentators evaluating the international research literature is discussed;
- An alternative perspective is presented; this questions how certain kinds of evidence is privileged in considering what works. This draws on the knowledge and experiences of those working in the field as well as service users.

2.1 Evidence from the research literature

Anderson, Chisholm and Fuhr (2009) reviewed the international research evidence on the effectiveness of programmes and policies to reduce alcohol-related harm. They concluded that policies that regulate the environment in which alcohol is marketed (in particular its price and availability) are effective in reducing alcohol related harm (Anderson et al, 2009). Enforced legislative measures to reduce drink-driving and individually-targeted interventions to drinkers already at risk were also found to be effective (Anderson et al, 2009). However, the evidence shows that alcohol information and education interventions are less effective (Anderson et al, 2009).

Tom Babor and colleagues evaluated the international research using three major criteria; evidence of effectiveness, breadth of research support, and the extent of testing across diverse countries and cultures (2010, p. 267). This is shown in Box 2 on page 14. The assessment reflects the consensus of 15 expert authors. They also concluded that the most effective interventions to reduce alcohol related harm include alcohol taxes, restrictions on availability of alcohol and measures to reduce drink driving, interventions identified as the least effective include alcohol education, public awareness programmes and designated driver schemes (Babor *et al*, 2010; Anderson *et al*, 2009).

Babor *et al*'s (2010) evaluation is of single interventions operating at a 'stand alone' level, however, as the authors note, such interventions rarely operate independently or in isolation from other strategies. Evidence from local prevention work suggests that multiple interventions implemented in a systematic way are more effective than single interventions (Babor *et al*, 2010); indeed, 'stand alone' is no longer accepted as a suitable model for dealing with complex health, criminal justice and social problems. This raises the question of how multiple interventions are best evaluated. Brennan and colleagues (2011) argue for the use of multiple outcomes; designs that capture the complex interactions across the physical environment, individuals and local community and build in evaluation from the outset. The

same authors conducted a systematic review of evaluation studies of interventions to reduce disorder and severe intoxication in and around licensed premises (e.g. responsible beverage service training (RBS), enhanced enforcement of licensing regulations), found little evidence to show that interventions could reduce intoxication and disorder (Brennan *et al*, 2011). The authors concluded that server training courses that are designed to reduce disorder have some potential, but that there is a lack of evidence to support their use to reduce intoxication (Brennan *et al*, 2011) and that this was in part a reflection of the challenges of evaluating such interventions and the limited nature of the evaluations.

Box 2: Criteria used to assess effectiveness, breadth of research support and cross national testing

‘Effectiveness’ refers to the likely effectiveness of the intervention, reflecting the strength of scientific evidence establishing whether a particular strategy is effective in reducing alcohol consumption and/or alcohol related problems.

Babor *et al* (2010) were concerned with the overall conclusion that “a reasonable person can draw based on the quality of research and the consistency of the effect under both idealized research conditions (efficacy studies) and real-world studies (effectiveness studies, including ‘natural experiments’)” (p.240). The following scale was used:

- 0 Evidence indicates a lack of effectiveness.
- + Evidence for limited effectiveness.
- ++ Evidence for moderate effectiveness.
- +++ Evidence for a high degree of effectiveness .
- ? No controlled studies have been undertaken or there is insufficient evidence upon which to make a judgement.

‘Breadth of research support’ considers the quantity and consistency of the available evidence, including conflicting evidence. Ratings were influenced by conclusions of meta-analyses and integrative reviews. Babor *et al* (2010) were concerned with the direction of the evidence independent of the number of studies conducted. Breadth of research was assessed independent of the effectiveness rating (i.e. it is possible for a strategy to be rated low in effectiveness but to also have a high rating on the breadth of research support criterion). The following scale was used:

- 0 No studies of effectiveness have been undertaken.
- + One or two well designed effectiveness studies completed.
- ++ Several effectiveness studies have been completed, sometimes in different countries, but no integrative reviews were available.
- +++ Enough studies of effectiveness have been completed to permit integrative literature reviews or meta-analyses.

‘Cross national testing’ means the evidence for a specific intervention was drawn from studies undertaken in different countries, regions, subgroups, and social classes. In assessing the evidence, Babor *et al* (2010) were concerned with the extent to which interventions developed for, and evaluated in, the established market economies can be transferred to developing societies. This criterion is thus concerned with the diversity of geography and cultures within each strategy as applied and tested. It refers to the robustness of international or multi-national testing of strategy as well as the extent to which a strategy applies to multiple countries and cultures. The following scale was used:

- 0 The strategy has been studied in only one country.
- + The strategy has been studied in at least two countries.
- ++ The strategy has been studied in several countries.
- +++ The strategy has been studied in many countries.

These conclusions emerge from reviews which privilege research based evidence over other types of evidence which draws on experience, accumulated knowledge and experimentation in the field.

2.2 Drawing on the knowledge and experience of practitioners and users

Decisions makers in UK health and social care are expected to base their decisions on the evidence of 'what works', however, Williams and Glasby (2010) argue that too much emphasis has been placed on a narrow definition of what counts as 'valid' evidence and which privileges certain approaches and voices over others. To date, evidence based practice and policy has been dominated by formal research and precedence has been given to quantitative methodologies, in particular random controlled trials and systematic reviews which are regarded as the 'gold standard' (Glasby and Beresford, 2006; Holmes, *et al*, 2006). These 'objective' methods are regarded as inherently superior, with other approaches such as qualitative research being seen as inferior and the views of practitioners and users generally cast aside as class 'V' evidence (Williams and Glasby, 2010). Glasby and Beresford (2006) call for a broader notion of 'knowledge-based practice', drawing on different types of research, the tacit knowledge of practitioners and the lived experiences of service users. However, as Williams and Glasby (2010, p. 96) note there are challenges:

“Whereas traditional notions of evidence based practice have relatively simple rules as to what constitutes valid evidence, how to judge quality and how to synthesise findings, there is no consensus about how best to reconcile these forms of explicit knowledge with the more complex (and less easily codified) dimensions of knowledge –based practice. As a result, there is danger of reverting to traditional notions of (medically dominated) research hierarchies – not necessarily because these result in better decisions but because they offer the promise of simpler decision-making by clearly defined rules and boundaries.”

Explicit knowledge can easily be codified in reports, policies and procedures, whilst it is difficult to codify and share tacit knowledge because:

- Its meaning is context dependent, and so for tacit knowledge to 'make sense' and be shared some understanding of the context is needed;
- It is made up of practical, experiential wisdom and the expertise of individuals and thus there are seldom external and formal accounts of tacit knowledge (Greenhalgh, *et al*, 2004).

Wharf Higgins, *et al* (2011) in a study of how public health practitioners in Canada defined and used evidence during the implementation of a Healthy Living initiative found that tacit knowledge strongly influenced their work (Wharf Higgins *et al*, 2011). Respondents defined

'evidence' broadly to include academic research, programme evaluations and more informal data e.g. stories and past experiences. "Grassroots", local, "lived experience" were described as highly significant to their work, which they combined with research from academia and clinical studies to produce a hybrid which, whilst underpinned with 'research', reflected the needs and wishes of the local community. This process is probably better described as knowledge 'transition' rather than translation to the local public health context (Wharf Higgins *et al*, 2011).

A distinction can be made between theoretical, empirical and experiential knowledge (see Table 2). Within health and social care research there is a tendency to look for empirical data of 'what works', but Glasby *et al* (2007) argue that a mix of all three types of knowledge are needed in order to make a fully informed decision that includes a deliberation of how and why an intervention might work, what outcomes it achieves and how it is experienced by practitioners and service users. In relation to public health, theory can play a potentially important role but as Kelly *et al* (2010) observed theories or models do not really have a place in an evidence based approach.

Table 2: A typology of evidence for decision making

Type of evidence	Description	How it contributes to knowledge
Theoretical evidence	Ideas, concepts and model used to describe the intervention, to explain how and why it works, and to connect it to a wider knowledge base and framework	Helps to understand the programme theories which lie behind the intervention, and to use theories of human or organisational behaviour to outline and explore its intended working in ways that can then be used to construct and test meaningful hypotheses and transfer learning about the intervention to other settings.
Empirical evidence	Information about the actual use of the intervention, and about its effectiveness and outcomes in use.	Helps to understand how the intervention plays out in practice, and to establish and measure its real effects and the causality of relationships between the intervention and desired outcomes.
Experiential evidence	Information about people's experiences of the service or the intervention, and the interaction between them, and the 'practical wisdom' of professionals and practitioners (Head, 2008)	Helps to understand how people (users, practitioners and other stakeholders) experience, view and respond to the intervention, and how this contributes to our understanding of the intervention

Source: Williams and Glasby (2010, p. 97).

Within the literature there has been a growing recognition of the limits of an approach that privileges largely quantitative, controlled academic research and the assumptions underpinning acceptance of its relevance to policy making. This all raises questions about the criteria used to judge 'what works', who decides what makes an intervention 'successful', and suggests that there is a need to look beyond the published international academic literature to help identify 'promising' initiatives. The alcohol field has considered successful initiatives from other fields such as smoking, HIV/AIDS (Stead *et al*, 2009) and also from the past (e.g. Berridge, 2005, on the temperance movement) to identify what might work. What is currently lacking is the perspective of those stakeholders who have experience 'on the ground' of developing and delivering alcohol projects. It is likely that stakeholders would suggest additional criteria to those derived from the research evidence.

3. Multi-component programmes – a framework for considering what works

3.1 Background

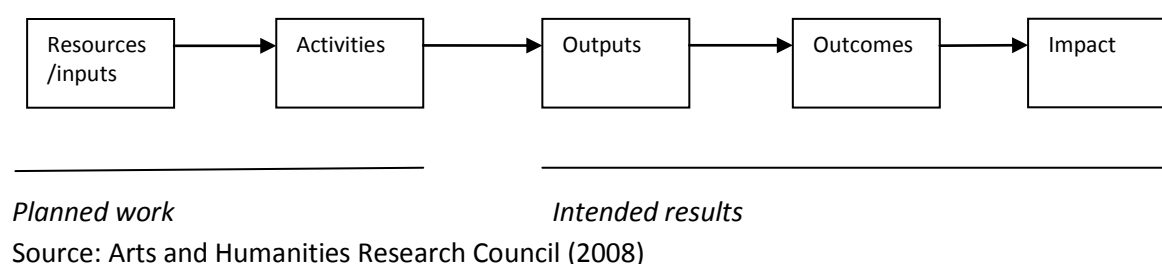
In recent years there has been growing interest in the potential of multi-component programmes (MCPs) as an approach to reduce alcohol related harm in the community. MCPs involve the identification of alcohol related problems at the local level and implementation of a programme of co-ordinated projects to tackle a problem. They are based on an integrative design where singular interventions run in combination with each other and/or are sequenced together over time; the identification, coordination and mobilisation of local agencies, stakeholders and community are key elements (Thom and Bayley, 2007). Whilst the specific targets of the multi-component programmes vary, the majority aim to influence community systems and change drinking norms, and most aim to mobilize local communities with the intention of securing sustainable, long-term change.

A key element of MCPs is that projects, or components, and the programme as a whole should have a strategic framework underpinned by a theoretical base. The 'systems theory approach', closely associated with the work of Holder and colleagues in the US (Holder, 1998), and the 'community action' approach have been particularly influential (see Thom and Bayley, 2007:35-39). The US, Australia and New Zealand were at the forefront in the development of multi-component programmes in the alcohol field and influenced the establishment of such programmes in Europe (e.g. Holmila, 2001) and the UK (Mistral *et al*, 2007).

Fundamental to the MCP approach is the choice of components or projects selected to address the overall aim of the MCP. Each component typically has its own aim and evaluation measure and components are chosen to be mutually reinforcing. For example, the 'Lions Breath' project in Cardiff included public awareness raising, server training, strict enforcement, environmental and transport improvements (Mistral *et al*, 2007). Whilst we know what is likely to work at a 'stand alone' level, how interventions work in combination is less clear or what kind of combinations are likely to result in an effective MCP. This is in part because of the expected synergistic effects of the components and also the possible cumulative effects over time; furthermore it has not been possible to identify the contribution of particular components to programme outcomes as a whole (US Department of Health, 2000). For example, educational and awareness raising campaigns are often cited as ineffective in changing behaviour (Babor *et al*, 2010; Anderson, *et al*, 2009) but are seen as a crucial element of most multi-component programmes. In response to the difficulties of identifying which components are effective in an MCP, where multiple interventions are

undertaken at the same time, Graham (2011) suggests using ‘logic models’⁶ (see Figure 1) that link measures of implementation to mediating variables and eventual outcomes. Graham (2011, p. 14) uses the example of Wagenaar *et al* (2000) who hypothesised that their community intervention would have greater effect on 18-20 year olds (the main target) than on 15-17 year olds. In fact they found similar effects for both age groups, suggesting that the intervention may have had an effect on community norms as well as effects attributable to the development of age-specific policies. Gauging the effectiveness of interventions can depend on which outcome is being assessed; for example, Graham (2011) points out that RBS (Responsible Beverage Service) is unlikely to have a significant effect on violence in bars but may sometimes reduce intoxication. She notes that, conversely, a programme addressing the management of problem behaviour, which does not include RBS, may reduce aggression but would not necessarily impact on intoxication.

Figure1: Logic model



Evaluation is an integral part of multi-component programmes; both the overall programme and the individual projects within it, should have clearly defined aims, objectives and measures of effectiveness (Thom and Bayley, 2007). Most MCPs test interventions in ‘naturalistic’ situations where variability in delivery of intervention and in acceptance of the intervention by the community is expected (Holder and Howard, 1992; Ross, 1992). Although classical experimental designs e.g. randomised control trials, may be used in some programme components (e.g. school based components), they are generally not a feasible method of evaluating MCPs that target change at community level. Some programmes have used randomisation in selecting intervention and control communities, for example, Communities Mobilising for Change, USA (Wagenaar *et al.*, 2002), Project Northland, USA, Williams *et al.*, 1999). Quasi-experimental approaches have been used widely, with projects choosing matched sites for comparison, for example, COMPARI, Australia (Midford and Boots, 1999), Project STAD, Sweden (Wallin, 2004). Whilst ‘before and after’ measures are

⁶ A logic model is a systematic and visual way of describing a programme or organization in evaluation terms. It illustrates a programme’s *theory of change*, showing how day-to-day activities connect to the results or outcomes the programme is trying to achieve. Similar to a flowchart, it lays out programme activities and outcomes using boxes, and, using arrows to connect the boxes, shows how the activities and outcomes connect with one another (Coffman, 1999).

common to MCPs, many have used interrupted time series, a more robust method, where measures are taken at several points before, during and after the intervention, for example, Communities Mobilising for Change, USA (Wagenaar *et al.*, 2002), Project STAD, Sweden (Wallin, 2004). As Thom and Bayley (2007) note, what is often missing from evaluation studies is a narrative account of action to help understand why projects may work in one setting and not in another. Holmila (2003, p. 83) suggests that programme evaluation should aim at presenting results in the form of “theory based narratives concerning the inner mechanisms of communities in action”. Thom and Bayley (2007, p.29) argue that narrative accounts would help in generalising evaluation results by creating a theory of action which could be tested and applied elsewhere.

Adapting an initiative that is effective in one area and transferring it to another is, of course, part of mainstream practice but, as Thom and Bayley (2007) point out, developing guidelines to assess the viability of transferring a particular initiative from one context to another is problematic. Notwithstanding this, they suggest a number of principles to be considered in attempting to transfer interventions, summarised in Box 3.

Box 3: Principles to consider in transferring initiatives

- Develop a sound theoretical base for the programme which considers the problem, the community and the rationale for the programme
- Take account of available research evidence and what has worked elsewhere
- Have a clear profile of the community, taking account of diversity of population groups, values, knowledge and interests and the potential for the gaining support for the initiative
- Consider the possibilities and limits of community involvement and the possible unexpected effects
- Look at local resources, priorities, capacity to take on the initiative (component or new programme) and opportunities to link with existing partnerships and coalitions
- Develop an action plan, an implementation strategy and evaluation plan

3.2 Introduction

This review aims to explore the concept and delivery of a range of multi-component programmes (MCPs) by examining the international literature. The aims and objectives of the different interventions themselves will be considered, together with the individual components deployed by the various projects to achieve their aims. Another key focus of

the review will be to critically reflect on the processes via which the interventions have been evaluated. While MCPs are strategically designed to include multiple components that are mutually reinforcing, synergistic effects can occur when components interact but these may not necessarily be positive (Thom and Bayley, 2007); these interactions therefore merit closer examination. In trying to identify what works it will also be important to highlight the challenges faced and opportunities that may develop in transferring interventions from one context to another. The review will conclude by considering those components or combinations of activities which offer the greatest potential with respect to reducing alcohol consumption and/or tackling alcohol-related harms.

3.3 Defining MCPs

In the absence of a single, universally-accepted definition of an MCP, a broad range of projects can be identified in the literature as representing examples of this type of intervention. Having acknowledged this diversity, Box 4, shown below, is a useful reminder of the criteria used to distinguish an MCP from a single component or stand-alone approach (Thom & Bayley, 2007).

Box 4: Criteria used to define an MCP approach

- The development of a strategic framework with a theoretical basis for action
- The identification of problems at the 'local level'
- The co-ordination of project actions to address problems via an integrated programme design where singular interventions run in combination with each other and/or are sequenced together over time
- The identification, mobilisation and co-ordination of appropriate agencies, stakeholders and communities
- Clearly defined aims, objectives, indicators and measures of effectiveness for the programme as a whole, although each component/project has its own specific aims, objectives and outcome measures
- Evaluation mechanisms built in as part of the programme from the start

On the basis of these criteria, the interventions identified in the literature can be grouped into a number of different clusters or typologies. While all self identify as MCPs, those that fully conform to a 'classical' model (based on fulfilling the criteria in Box 4) can be seen as different from those that share some, but not necessarily all of these characteristics and that may also have a particular focus. This contrast can be seen most clearly between MCPs that include discrete stand-alone components, each of which have clearly distinct aims (for example, education, enforcement, responsible beverage service etc), compared with those that combine a number of 'umbrella activities' whose aims all fall broadly under a common

theme and where activities are interdependent. An argument could be made for rejecting MCPs that do not follow the classical model; however this runs the risk of rejecting some combinations of components and activities that may still offer potential to reduce alcohol related harm / consumption. We believe it is more productive to think in terms of the following MCP clusters or typologies: classical, education-based, enforcement-led, survey/information focused, tax and fund MCPs. Examples from each of these five typologies can be seen in Boxes 5 to 9 below:

- **Classical** – at least three discrete components each with its own aims and objectives, often evaluated via multiple outcome measures. Examples of this typology are the Trelleborg project (Sweden), Lion’s Breath (UK), Compari (Australia), CTIRHRD (US) etc.

Box 5: a US-based MCP that conforms to the classical typology – Neighbourhoods engaging with students (Washington)

Aims: To explore the effectiveness of a university-based intervention designed to reduce heavy episodic drinking and ‘disruptive off campus parties’ via an MCP that sought to deliver increased ‘student integration into and accountability to the neighbourhoods in which they live’ (Saltz *et al*, 2009: 21).

Components: the project comprised four components:

- Enforcement: interventions including increased party/alcohol emphasis patrols and increased compliance checks at on-premise establishments
- Education about alcohol harms/rights and responsibilities associated with living as part of a community
- Web and media-based information
- Community engagement: bringing students and community members together to participate in a Neighbourhood Mediation Program to assist with the resolution of future disputes

Survey and results: Data were collected via pre and post-intervention web-hosted, self-completion questionnaires and the patrols. The intervention reported ‘a significant reduction in heavy episodic drinking in [the] two intervention sites relative to a third campus... although the evaluation did not allow us to determine the impact of specific neighbourhood engagement or educational strategies separate[ly] from enforcement’. Difficulties occurred in attempts to facilitate greater student/community engagement because the project encountered a ‘culture gap between neighbourhood associations and the university’ (Saltz *et al*, 2009: 26 & 27). The Neighbourhood Mediation Program was discontinued.

Conclusion: The project achieved impressive outcomes across a year with respect to reduced heavy drinking, although the authors query the sustainability of these reductions. In terms of component effectiveness: ‘the evaluation did not allow us to determine the impact of specific neighbourhood engagement or educational strategies separate from enforcement... further research could provide a better understanding of the relative impact of specific components’ (Saltz *et al*, 2009: 26). From a promising approaches perspective, it is interesting to note the comment that ‘there is every reason

to suppose that we are still in the early stages of understanding how to replicate these results with even greater impact and with more efficiency' (Saltz *et al*, 2009:27).

- **Education-based** – interventions that focus primarily on preventing alcohol use/delaying its onset or reducing levels of consumption (harm minimisation) via the use of various education-related activities. These could include combinations of: school action plans, teacher training, teacher and/or peer-led learning, child/parent activities, community education initiatives. Examples of projects that embrace such an approach include Project Northland (Chicago and Croatia) and SHAHRP (see Box 6). Many such interventions seek to influence both alcohol-related attitudes and behaviours.

Box 6: An example of an education-led MCP –the School Health and Alcohol Harm Reduction Project (SHAHRP) (Australia)

Aims: to assess the effectiveness of an MCP aimed to reduce alcohol-related harms experienced by secondary school students via a two stage education-based intervention; stage one undertaken at age 13yrs and stage two a year later.

Components: the project employed four components or 'activities'

- Teacher training to inform teachers of the project's aims, develop their awareness of the context in which it was taking place, and enable them to deliver various classroom-based activities
- Teacher manual providing written guidance about the intervention including detailed lesson plans, sample discussion questions and debriefing strategies
- Student workbooks produced as learning resources around which the practical, inter-active activities were developed
- Trigger video featuring alcohol use scenarios that young people would be likely to encounter

Survey and results: an anonymous, self-completion questionnaire was used to measure students' knowledge of and attitudes towards: alcohol, their patterns of alcohol use and self-reported harms. The sample included over 2300 students and the retention rate across the programme was 75%. Evaluation of the project identified significant knowledge, attitudinal and behavioural effects particularly during the first stage of the intervention, with substantial (but declining) reductions in 'risky' drinking and self-assessed alcohol-related harm reported by students in the intervention schools.

Conclusions: in addition to noting the rapid impact of the intervention on drinking behaviours, intervention students were 'much less likely to consume alcohol in a harmful or hazardous manner' than controls receiving standard alcohol education. Of potential interest, McBride *et al* (2004) report that 'the study found that a harm reduction programme which does not solely advocate non-use or delayed use can produce larger reductions in alcohol consumption' than those that promote abstinence and that 'classroom programmes offer the greatest opportunity to impact on young

- **Enforcement-led** – interventions that centre on increasing the level of police/licensing authority attention directed towards a particular alcohol reduction objective. Project components are often configured with the aim of reducing sales of alcohol to those under-age, refusing service to intoxicated patrons or decreasing the incidence of drink driving. Examples of projects based on this approach include the STAD project (see Box 7 below), Operation Safe Crossing, the Auckland Regional Community Action Project (ARCAP) and the Complying with the Minimum Drinking Age (CMDA) project.

Box 7: An example of an enforcement-led MCP - STAD Project (Sweden)

Aim: This community-based MCP was introduced to reduce the incidence of alcohol service to already intoxicated patrons in licensed premises (Wallin *et al*, 2005).

Components: The project comprised three main components:

- A community mobilisation strategy that led to the formation of a steering group comprising representatives of the police, licensing authorities and hospitality industry
- A Responsible Beverage Service (RBS) training course for employees of bars, pubs, restaurants and nightclubs in the project area
- Stricter enforcement of existing regulations primarily via a sharp increase in the sending of notification letters to licensed premises perceived to be over-serving

Survey and results: Pseudopatrons (actors portraying extreme intoxication) visited a total of around 800 licensed premises three times: a 1996 baseline study, a 1999 follow up and a second follow-up in 2001. Results demonstrated a significant decrease in rates of service refusal in both areas (from 5% at baseline to between 60% and 80% at second 'follow up'). However, refusal rates were actually higher in the control area by the time of the second 'follow up' (ibid).

Conclusions: Results demonstrate that it had become more unlikely that an overtly intoxicated person would be served alcohol in central Stockholm. Wallin *et al*, (2005) acknowledge that 'the refusal rate was actually higher in the second follow-up in the southern part (control area)' (p. 811) and comment that 'the improvement was statistically significant' for both control and intervention areas (ibid).

- **Survey and information-focussed** – projects designed around alcohol knowledge/attitude/behaviour surveys, which are used to construct an individual profile and tailor information/support/advice to them. Some projects made use of online delivery of surveys and information and these appear to be popular in US College settings e.g. My Student Body and Heads UP! See Box 8 overleaf.

Box 8: An example of a survey and information-focussed intervention (US)

Aim: to investigate the efficacy of an interactive website providing individually-tailored, motivational advice with the aim of reducing alcohol consumption by college students identified as 'binge drinkers' (Chiauzzi *et al*, 2005).

Background: as with the 'Neighbourhoods Engaging Students' initiative (see Box 5) concern about increasing levels of student alcohol consumption was the main driver of the intervention. However, concerns about alcohol-related harms at the individual level (health problems, sexual and physical assault, vandalism, negative impact on academic attainment) were of key interest. The relationship between gender and alcohol consumption/related harm was also explored. More specifically, the programme sought to build on the BASICS (Dimeff *et al*, 1999, cited in Chiauzzi *et al*, 2005) which provided information / tailored advice to students via face-to-face and group sessions as opposed to the web-based delivery deployed by this intervention. The increased availability of computers on college campuses is given as the main reason for this transition, although the fact such an approach is widely considered 'less intrusive' is also mentioned (*ibid*).

Components: the project employed the following components / 'activities':

- Information about alcohol and related risks including how to access emergency help
- A 'Rate Myself' component requiring students to provide information about their alcohol-related attitudes/beliefs, behaviours/risk-taking and any negative consequences experienced as a result of their drinking on which they received individually-tailored, online feedback
- An 'ask the expert' interactive tool
- State law and social norms 'calculators'

Survey and results: 265 students participated in the intervention; half were allocated to the intervention website and half to the control and each was gender balanced. Each participant was required to complete four 20 minutes sessions per week on which they received online feedback. Evaluation was carried out pre and post intervention at one and three month follow-ups. In terms of overall results, all participants were found to have reduced their frequency of binge drinking episodes, although a 'significantly higher rate of reduction' in maximum number of drinks per binge drinking session was reported by the intervention group immediately post-intervention. This was not, however, sustained at the three month follow-up. In addition 'persistent heavy drinkers in the experimental group experienced a more rapid decrease in average consumption and peak consumption than their control group counterparts' (Chiauzzi *et al*, 2005: 269). Female members of the intervention group reduced their 'special occasion' alcohol consumption more than controls and reported 'significantly fewer' negative consequences related to their drinking. The authors comment that they believe such results may be generalisable.

Conclusions: the authors assert 'the positive outcomes in our study suggest the intervention offers a potentially effective means of delivering brief interventions to college student drinkers' (Chiauzzi *et al*, 2005:272) They suggest that the benefits might be greatest for women. The less intrusive (i.e. not face-to-face) nature of the intervention is hypothesised as being a factor in the results achieved and

the high retention rate (80%). However, the authors also acknowledge that in the absence of a 'controlled component analysis' it is not possible to assert which aspects of the intervention accounted for the changes. Finally, problems inherent in results that depend on self-report are noted.

- ***Tax and fund*** – interventions that impose hypothecated alcohol taxes.

Hypothecation is where part of the tax revenue raised from the sale of alcohol is earmarked to address alcohol related harms or misuse, for example to fund enhanced alcohol support or treatment services. Such initiatives are dependent on local decision-makers having the remit to increase alcohol taxes/impose levies. In view of the lengthy timescales involved, it is important that measures are employed to monitor both acute and chronic outcomes. Implementing and evaluating an intervention of this type clearly has its difficulties, not least in selecting an area that is fairly isolated to avoid increased cross 'border' purchasing. The Northern Territory's Living With Alcohol programme provides an example of this type of MCP (see Box 9 overleaf). This example usefully illustrates how action at the local level can be constrained by national frameworks, in this case, taxation policies.

Box 9: An example of a ‘tax and fund’ MCP intervention - Living With Alcohol (LWA) (Australia)

Aim: to evaluate the impact of the Living With Alcohol (LWA) program, which sought to reduce levels of alcohol consumption and related harm to the national average. The intervention was aimed at both Indigenous and non-Indigenous Australians.

Background: Per capita alcohol consumption in the intervention area (Northern Territory) had been the highest in Australia and almost twice the national average (Chikritzhs *et al*, 2005). In response, the LWA program was introduced in 1992. A prominent aspect of the initiative was to impose an additional financial levy on beverages with alcohol content greater than 3% (5 cents on a ‘standard’ drink) in an attempt to reduce aggregate demand but also raise revenue to finance enhanced alcohol treatment services. A parallel education programme was run to increase the efficacy/profile of the intervention. A 1997 High Court ruling required the removal of the levy (which resulted in a real terms fall in the price of 3%+ alcohol) but the programme continued to be funded from general revenue.

Components: The project comprised three main components:

- Supplementary financial levy on 3%+ alcoholic beverages
- Education program
- Expanded treatment and rehabilitation services

Survey and results: The Chikritzhs *et al* (2005) study draws on Northern Territory mortality data to gauge the effectiveness of the LWA intervention. The research represents an update of an earlier evaluation undertaken by Stockwell *et al* (2001), which indicated over the programme’s first 4 years, (between 1992 and 1996), that there were significant reductions in economic and health costs of alcohol misuse especially for *acute* alcohol-related harms. The Chikritzhs *et al* evaluation reports that *acute* alcohol-attributable deaths in the Northern Territory had declined by 36.6% during the course of the intervention (compared to 15.9% in the control area), whilst deaths attributed to *chronic* conditions declined by 26% across the intervention period (the corresponding figure for the control being 15.6%). The authors report ‘significant declines in *acute* alcohol-attributable death rates for both Indigenous and non-Indigenous [NT] residents’ (p. 1633).

Conclusions: The authors assert that ‘the results of this study present a strong argument for the efficacy of combining alcohol taxes with comprehensive programs and services designed to reduce the harms from alcohol’. Furthermore, they comment that ‘without the support of price increases, programs and services for reducing alcohol related harms may have limited benefits for reducing harms that tend to arise from episodes of drinking to intoxication’. The paper concludes ‘this evaluation also supports the conclusion that the combined impact of programs and services with an increase in the real price of alcohol is effective in reducing acute harms among both Indigenous and non-Indigenous communities’ (p. 1635)

The great majority of the projects identified in the literature can be classified under one of the five typologies (see Table 3 below). Eleven MCPs are consistent with the ‘classical’ model, while the others are spread across the remaining typologies. This illustrates the range and variety of MCP interventions being considered in this review, which will be useful in analysing the wide range of potential promising approaches.

Table 3: Interventions classified by MCP typology⁷

CLASSICAL	Trelleborg Project; STAD (Stockholm Beer Campaign); Alcohol, less is better; Alcohol Abuse Prevention Program (Missouri); Fighting Back ⁸ ; Cardiff ‘Lion’s Breath’; COMPARI; Neighbourhoods Engaging with Students (Washington); YATA; Aquarius ‘Route 50’ project; CTIRHRD
EDUCATION-BASED	SHAHRP; Project Northland Chicago; Project Northland Croatia
ENFORCEMENT-LED	PAKKA; ARCAP; Hawera Alcohol and Young People Project; Phia Booze and beach ban; Operation Safe Crossing; STAD (Over-serving Project)
SURVEY & INFORMATION BASED	Heads UP!; Think before you buy under-18s drink; Orebro Prevention Program; PRIME for Life; My Student Body; Wed-based self-help for problem drinkers; JASAP
TAX AND FUND	Living With Alcohol (Northern Territory)

3.4 Aims of MCPs

Holder *et al* (2000) advise that interventions should have clearly focussed objectives as opposed to more general aims such as simply ‘reducing alcohol consumption’. Targeting a specific age/social group similarly appears to enhance the potential effectiveness of an MCP (Chiauzzi *et al*, 2005). Although reducing alcohol consumption and/or alcohol-related harm was the overall aim of all MCPs, the MCPs identified via the literature search process exhibited a wide range of aims and objectives with some projects/interventions stating a single aim, whilst others outlined multiple aims (see Table 4). In a number of cases, programmes with multiple aims sought to directly influence both attitudes and behaviours. This was especially true for the education-based and survey and information-focused interventions. Target group also varied by project. In overall terms, although these tend to be project-specific, prominent aims included:

⁷Three of the projects reviewed in the identified literature did not lend themselves to classification using these typologies.

⁸ This initiative represents a cluster of 12 projects across the US. Although subject to some degree of variation, all appear to conform to a classical model

- Reducing/preventing consumption by young people
- Addressing alcohol-related violence/anti-social behaviour
- Reducing negative health impacts/alcohol attributable deaths
- Combating drink driving

Table 4: Main aims and target group of MCPs evaluated in the identified literature

MCP Aim	Target group	Number of projects/interventions
Reducing alcohol service to intoxicated clients	Adults	2
Reducing alcohol supply by adults to children/underage drinkers	Parents and young people	2
Preventing underage alcohol purchase/drinking	Young people	7
Gauging levels of alcohol consumption by young people	Young people	2
Delaying the onset of alcohol consumption by young people	Young people	3
Reducing alcohol-related violence/anti-social behaviour	Adults and young people	9
Reducing health harms (harm minimisation) and/or alcohol attributable deaths	Primarily adults, but also young people in some cases	15
Reducing drink driving/alcohol-related Road Traffic Accidents (RTAs)	Adults	3
Evaluating the efficacy of Responsible Beverage Service (RBS) initiatives	Pub/bar/nightclub/restaurant staff	3
Assessing the effectiveness of enforcement of alcohol policies/laws	Off license owners/workers	4
Investigating the effectiveness of an internet-delivered self-help intervention	Alcohol users accessing the particular intervention	1

N.B. Multiple aims are possible

In addition to the observation that many projects have multiple aims, it should be noted that categorising the aims of the different interventions is problematic because in certain circumstances these cross-cut e.g. interventions designed to 'Reduce drink driving/alcohol-related RTAs' self-evidently also 'Reduce health harms (harm minimisation) and/or alcohol attributable deaths'.

3.5 MCP Components

The projects explored in the literature included both those that comprised three or more discrete, standalone components (classical model) and those that built a number of

‘activities’ or subcomponents around a common theme (the other typologies). The number of components, as defined by the projects themselves, ranged from two to 22 (see Appendix 2 for a breakdown of projects by component/activity). The lack of standardisation in terms of what constitutes a component (as opposed to an activity or sub-component) goes a long way to explaining this wide range, with some initiatives referring to ‘education campaigns’ as a single component (the Italian ‘Alcohol, less is better’ project, or LWA, for example) , whilst others would break this down into its constituent parts with ‘teacher-led school activities’, ‘peer-led school activities’, ‘child and parent discussion activities’ being classified as separate components (e.g. Project Northland Chicago). Information-based components and media-related components were two others subject to variable definitions and subsequent counting procedures. As with the aims/objectives, the projects incorporated a wide variety of different components, however, they can loosely be grouped into the following categories:

- Enforcement (age restriction, licensing laws, drink driving, Pub watch schemes)
- RBS training
- Media campaigns/advocacy
- Information campaigns
- Education (teacher training initiatives, school action plans, child and parent discussion activities)
- Key stakeholder engagement/steering group formation
- Enhanced treatment and rehabilitation provision
- Community mobilisation

See Table 5 below for a summary of the number of projects that incorporated the various different components based on the above categories:

Table 5: Number of projects employing the different types/categories of component

Types/category of component	Number of projects
Enforcement (age restriction, licensing laws, drink driving, Pub watch schemes)	11
RBS training	5
Media advocacy	9
Information campaigns	11
Education (teacher training initiatives, school action plans, child and parent discussion activities)	9
Key stakeholder engagement/steering group formation	6
Enhanced treatment and rehabilitation provision	3
Community mobilisation	9

3.6 Evaluating MCPs

Challenges in methods used to evaluate MCPs

It is not surprising to find that the diverse nature of the MCP interventions resulted in the use of a wide variety of outcome measures to evaluate interventions. And although these tended to make use of pre and post-intervention survey data (see Appendix 3), the different proxy indicators selected for the purpose of evaluating effectiveness make comparison across the different MCP interventions difficult. Along with the difficulties that using proxy indicators creates, there are a number of other methodological challenges that MCPs face which are summarised in Box 10 below.

Box 10: Challenges in methods used to evaluate MCPs

- Use of proxy indicators to evaluate effectiveness may not fully capture the extent of effectiveness or may overstate success
- Confounding factors e.g. other local activities influencing outcomes
- Appropriateness of outcome measures e.g. questionnaires may be not be sensitive to measuring certain changes
- Limitations in test purchasing designs e.g. use of actors to purchase alcohol
- Limitations in using self report measures of drunkenness – can be too subjective
- Sampling and selection biases
- Capturing the impact of several different components via a single outcome measure
- Attributing the relative effectiveness of specific components within the MCP

- *Proxy indicators*

The choice of proxy indicators, used extensively as evaluation mechanisms, is difficult to assess and has the potential to significantly affect the reported impact of an intervention. In some circumstances this may result in the effectiveness of an intervention not being fully captured, whereas in others it could lead to an overstatement of success. This has important implications especially where consideration is being given to mainstreaming apparently effective interventions. In recognition of this, it is acknowledged that there are ‘many methodological challenges to implementing and evaluating interventions in the community’ (Graham, 2011: 715).

- *Confounding factors*

The potential influence of confounding factors is well documented (Voas *et al*, 2002; Hallgren *et al*, 2009; Chikritzhs *et al*, 2005). For example, Voas *et al* (2002) note that other local activities taking place at the time of their intervention could have confounded their results and observe that their results could be part of a downward trend present before testing.

- *Choosing outcome measures*

A number of articles call into question the appropriateness of the outcome measures used to evaluate interventions. For example, Dixon and McLearn (2002) suggest that ‘the questionnaire used in this [the Missouri Alcohol Abuse Prevention Program] study was too crude in its ability to detect any changes in knowledge which may have occurred’ (2002: 21). Both Wallin *et al* (2005) and Warpenius *et al*, (2010) acknowledge that there are limitations associated with the use of pseudo-intoxicated (actor) purchase attempts. Similarly, several studies (e.g. Koutakis *et al*, 2008) used self-reported measures of drunkenness which the authors suggest are intrinsically subjective. Sampling issues and selection bias, such as those highlighted in the 2007 Stafstrom and Ostergren⁹ article are also significant and should be considered carefully. These reflections are of particular interest in attempting to identify promising approaches as effectiveness can only be measured satisfactorily where robust, valid outcome measures have been used.

- *Single versus multiple outcome measures*

Further challenges associated with evaluating MCP interventions concern the difficulty of accurately capturing the impact of several different components via the use of a single outcome measure, together with the problems inherent in trying to attribute the relative effectiveness of the constituent components that make up an MCP, especially if there are a substantial number of them (Wallin *et al*, 2003). The first of these issues could be addressed by the use of multiple outcome measures, which would offer the possibility of gaining a better understanding of the contributions of the individual components, acknowledged to be a limitation of current evaluation mechanisms by a number of authors (e.g. Brennan *et al*, 2011; Graham, 2011). Issues relating to the appropriateness of the outcome measures would still apply irrespective of the number used, but multiple outcome measures would also offer the potential to gain a more nuanced insight into the effectiveness of an MCP intervention.

Incorporating qualitative techniques into the evaluation process may offer the potential to gain a better understanding of the effectiveness of different components and how

⁹Stafstrom and Ostergren (2007) acknowledge that, due to potential selection bias, the most marginalised section of the school population, (with the potentially most advanced alcohol consumption habits) may have been underrepresented in the sample.

they are being received by communities. A qualitative evaluation can provide useful insights into how interventions can be improved or made more effective. An example of the latter is provided by the evaluation of Project Northland in Croatia which reported that:

‘the qualitative information from youth, parents, and teachers all indicated that the program – in order to be more effective – needs to begin at a younger age’ (West *et al*, 2008: 69)

Challenges in MCP evaluation design

Alongside the challenges regarding the methods used in evaluating MCPs, there are a number of considerations to be taken into account that concern the design of an MCP evaluation and these are outlined in Box 11.

Box 11: Challenges in MCP evaluation design

- Evaluation needs to be built in from the start of the programme, ideally not when interventions are already being delivered.
- Sustainability of an MCP - assessing the appropriate time frame for evaluation – too early and impacts may not be captured.
- Where a project has multiple aims, only some are achieved.
- Isolating intervention areas especially where a control area is used. Intervention ‘leakage’ may occur into control area or vice versa - activities in control area may leak into intervention area.

- *Evaluation should be built in from the start of the MCP*

When MCPs are developed within a classical typology, evaluation should be designed as an integral part of the overall MCP design. Brennan *et al*, (2011), in a systematic review of interventions focussing on licensed premises, reiterates this important recommendation regarding the need to build evaluation in at the planning and development stage of an intervention programme. While this is a characteristic of classic MCPs the authors note that evaluation may often not be implemented till later stages when interventions are already being delivered.

- *Sustainability and appropriate evaluation time-frames*

A further difficulty in evaluating effectiveness concerns the sustainability of an intervention’s impact and the appropriateness of particular time-frames used to measure longer term effects. These challenges are illustrated by Huckle *et al*, (2005) in their review of the Auckland Regional Community Action Project (ARCAP), an intervention which sought to reduce alcohol purchasing from off-licences by minors. A

significant decrease in sales was reported from baseline to first follow-up (60% to 46%), however sales reverted to almost baseline measures at second follow-up (55%). If only a first follow-up had been carried out, claims for the intervention's success could well have been made, however the effects of the intervention do not appear to be sustainable in the long term. Interestingly, a 'sister' project (Hawera Alcohol and Young People Project), carried out in a rural district during the same period, returned both a more pronounced reduction, but also one that was sustained over the research period (ibid).

- *Multiple aims may not be achieved*

Some projects were designed with multiple aims where one or more were achieved, but others not. The Missouri 'Alcohol Abuse Prevention Program' serves to illustrate this. Although it is reported as being effective in developing more 'protective attitudes regarding drinking and alcohol abuse' amongst students in the intervention area, it did not have any discernable impact on their drinking behaviours (Dixon and McLearn, 2002). These effects were replicated in other projects attempting to change both attitudes and behaviour (e.g. Project Northland Chicago). The conclusion that can be drawn is that such projects were partially effective in meeting some, but not all, of their objectives.

- *Isolating interventions and use of control areas*

In many cases, the use of control areas to compare results is problematic in judging if interventions have been effective. A relevant example is provided by Wallin *et al* (2005) in which the authors review a project (part of the Stockholm Prevents Alcohol and Drug Problems, STAD) that sought to reduce the prevalence of service to already intoxicated patrons (for more details of the project see Box 7). A sharp increase in the refusal rate, from 5% (at baseline) to 61% (at second follow-up) would, at first glance, appear to represent an impressive endorsement of the intervention. However, refusals had simultaneously increased from 5% to 82% in the control area, casting significant doubt upon the programme's impact and illustrating the difficulty in isolating interventions, especially when their success is widely reported in the media. Similar reductions were recorded in both intervention and control areas by Rehnman *et al* (2005) in their examination of a project (also part of the STAD initiative), designed to restrict underage youth alcohol purchasing. Both of these projects serve to illustrate the difficulties inherent in using control (or comparison) areas as a benchmark against which to gauge the effectiveness of an MCP intervention, a shortcoming acknowledged by a number of authors (e.g. Wallin *et al*, 2003; Rehnman *et al*, 2005).

The use of control areas creates difficulties in evaluating whether interventions have been *ineffective*, especially where similar change has been observed in the control area; or whether the effects of the intervention 'leaked' to the control area, suggesting that

the intervention could in reality have been effective. In some circumstances such methodological problems could be mitigated by careful selection of appropriate control areas (situating them a significant distance apart, for example), however, in others, selecting appropriate control areas could present considerable difficulties. For instance, the violence reduction project (another STAD intervention), evaluated by Wallin *et al* (2003), was influenced by many potentially confounding variables (including changes in patronage of the licensed premises in the intervention and control areas over the project period as a result of changing fashions/tastes) so that the authors caution:

‘the results from this study support the notion that the reduction in violent crimes is most likely related, in part, to the activities initiated by the community alcohol prevention program in the intervention area’ (Wallin *et al*, 2003: 276).

Despite these limitations, it is nevertheless worth considering the extent to which certain projects were deemed to have been effective in meeting their headline aims, and to determine which types of initiative and their components were found to be particularly effective. Appendix 3 presents this information in tabular form.

Assessing the effectiveness of components

Identifying effective component(s)

Assessing the contribution or effectiveness of different components separately from that of the overall intervention is a major challenge for MCPs and a key area of interest in identifying ‘promising approaches’. A number of authors generally advise that ‘on the basis of the data available for this study, it is not possible to specify the impact of each component separately’ (e.g. Wallin *et al*, 2003: 275). Others highlight more complex difficulties in evaluating individual components, as illustrated in the following example, where, over time, two components became indistinguishable from each other and the purpose of each specific component becomes more ambiguous.

‘A little insight into the [Western Washington University’s ‘Neighbourhoods Engaging with Students’] program may be valuable here. In reflecting on the intervention, enforcement efforts and neighbourhood management strategies became less distinct as time passed. Enforcement came to be viewed as an educational strategy in and of itself, as it communicates and upholds community expectations’ (Saltz *et al*, 2009:26).

Despite such difficulties in evaluating individual components, the effective integration of the components evident in the above example could be regarded as synonymous with synergistic effects; this is discussed further in the next section.

Overall ineffective MCPs but with effective components

When an MCP shows overall success in achieving its aims, components are usually evaluated to determine which have yielded the greatest impacts; however it is important to remember that programmes demonstrating little or no overall effects may still include components that are effective. Project Northland (Chicago) illustrates this well; it was found to have had no impact on the intervention community when compared with controls, however secondary analysis assessing the effects of the programme components revealed the parent/child activities component as returning 'promising' results (Komro *et al*, 2008).

Which components work consistently well?

In examining which components work, enforcement components appear to have produced positive outcomes in virtually all projects where they have been deployed, reaffirming the conclusions reached by Babor *et al* (2003) who asserts that they are often the most effective. For projects such as the Phia 'Booze and beach ban' the contribution of the enforcement component to achieving a sustainable reduction in alcohol-related anti-social behaviour is clearly noted (Conway, 2002).

Synergistic effects

The synergistic effects that are often a feature of MCPs are discussed by Thom and Bayley (2007), in particular, interactions brought about by introducing components which are mutually reinforcing. In this review, several articles make reference, either directly or inferentially, to the concept of synergy (Conway, 2002; Wallin *et al*, 2003; Wallin *et al*, 2005). Holder *et al* (2000) highlight the synergistic effects of particular components as a requirement to institutionalising change in the structures surrounding alcohol use in the CTIRHRD project:

'Designed to act synergistically to reduce alcohol-related death and trauma... the 5 prevention components at each intervention site... [are] focused on changes in the social and structural contexts of alcohol use that would alter acute heavy drinking which, in turn, would reduce injury and death (2000: 2342)

There are other references to the concept of synergy even if the term is not used directly. For example, Conway asserts:

‘Throughout this initiative [the Phia ‘Booze and beach ban], exchange of knowledge on harm reduction strategies was ongoing. There was considerable interaction between different groups and agencies relating to other issues in addition to alcohol. At meetings, different sectors such as the local council, police and community groups shared information on traffic and water safety, liquor licensing, media advocacy, resource production and distribution... council networks and processes were built on to advance other inter-sectoral initiatives’ (2002: 175).

This testimony suggests that there is often added value to be derived from MCP interventions, particularly where effective key-stakeholder engagement can be secured. In view of this, it is likely that the benefits of partnership working and ‘combining activities’ (Wallin *et al*, 2005) will continue to be advocated. It does, however, pose the question of how synergistic effects can be measured and further endorses the need for integrating qualitative approaches in evaluation.

Effectiveness of MCPs

The ability to determine whether an MCP intervention has been effective is, of course, of vital importance. As mentioned earlier, an integrated mechanism to evaluate effectiveness is considered to be a defining feature of MCPs (Thom and Bayley, 2007) and the projects considered in this review can broadly be viewed as incorporating this requirement with the proviso, noted in the Brennan *et al* (2011) review, that evaluation may not necessarily have been part of the initial project design.

The great majority of the projects discussed in the literature were effective to some extent in meeting one or more of their objectives, although the degree to which this occurred varied significantly (see Appendix 3). However, some, such as PRIME for Life and the STAD ‘Stockholm Beer Campaign’ were generally ineffective. By way of example, many of the interventions managed to reduce alcohol consumption and/or alcohol-related harms (Trelleborg Project; Alcohol, less is better; Living With Alcohol; COMPARI – discussed in Stafstrom *et al*, 2006; Bagnardi *et al*, 2010; Chikritzhs *et al*, 2005 and Midford *et al*, 2005 respectively), while others were only able to change attitudes (Missouri-based ‘Alcohol Abuse Prevention Programme’).

Classical MCPS

- The majority of the projects categorised within a classical model were reported to have been effective, although the enforcement component can explain the performance of some of these interventions (Western Washington University’s ‘Neighbourhoods Engaging with Students’; COMPARI).

Enforcement-led MCPs

- The enforcement-led projects were reported as achieving good outcomes (Operation Safe Crossing; Hawera Alcohol and Young People Project; PAKKA).
- Projects that sought to reduce alcohol service to already intoxicated patrons (STAD 'Over-serving at Licensed Premises in Stockholm' project; PAKKA) produced particularly good outcomes in terms of service denial but also a 20% decrease in violent crime in one of the intervention areas (Warpenius *et al*, 2010; Wallin *et al*, 2003; Wallin *et al*, 2005).
- A lack of enforcement measures was attributed to be at least partially responsible for the ineffectiveness of the 'Stockholm Beer Campaign' (Rehnman *et al*, 2005). A concern with some projects is the difficulty in sustaining changes in attitudes and/or behaviours once the intervention concludes; for example those enforcement-led initiatives seeking to improve ID verification (ARCAP; CMDA).

Education-based and survey and information focused MCPs

- The education-based and survey and information-focused MCPs returned a variety of outcomes. The SHAHRP project shows evidence of both attitudinal and behavioural change, although others (e.g. Project Northland Chicago; Project Northland Croatia) proved less effective.
- The US College survey and information-focused interventions (Heads UP! and My Student Body) report positive outcomes in reducing alcohol consumption. Chiauzzi *et al* (2005) make the valid point that the 'less intrusive' nature of these interventions is significant in securing the participation of some individuals.
- A key concern with these types of project is the difficulty in sustaining changes in attitudes and/or behaviours once the intervention concludes.

Tax and Fund MCP

- The Living with Alcohol MCP reported very positive outcomes with significant reductions in economic and health costs of alcohol misuse, especially for acute alcohol related harms.
- The Living with Alcohol project called for a longer term approach to be taken in evaluating the programme's effectiveness in order that changes to levels of both acute and chronic harms would have time to fully manifest themselves.

More specifically, the literature supports the views of commentators such as Babor *et al*, (2003) and Room *et al*, (2005) who assert that pricing and taxation mechanisms, regulation of the physical availability of alcohol, certain modifications to the environment or context in which alcohol is sold and consumed and drink-driving counter-measures represent the most

effective intervention mechanisms (Babor *et al*, 2003; Room *et al*, 2005). In contrast, the same authors are sceptical of education, promotional and 'persuasion' interventions (*ibid*). However, some types of initiatives are not discussed in their articles and, on the basis of the evaluations identified in this review, there are a number of exceptions to this analysis which will now be considered.

The Living With Alcohol (LWA) programme (Chikritzhs *et al*, 2005 – see Box 9) suggests that increasing the price of alcohol represents an effective means to reduce consumption and associated harms. However, there is no reference to the level of reduction in alcohol consumption that occurred as a result of the introduction of the 5 cent levy on all drinks containing 3%+ alcohol or, correspondingly, the impact on consumption of its abolition. Notwithstanding this, Huang (2003) proposes some interesting elasticity for price change in the UK context via statistical modelling. This suggests that beer sold in pubs/bars has an elasticity of -0.48p, beer purchased for home consumption -£1.03, wine -0.75p (drinking context not specified), and spirits -£1.31 (again, context not specified). This elasticity suggests that the potential to achieve reductions in alcohol consumption and associated harms via price increases is highly significant (cited in Room *et al*, 2005). Issues associated with the political acceptability of above-inflation price increases, industry opposition, and the limiting effects of common area agreements (Wallin *et al*, 2005), however, represent obstacles to any government seeking to implement such a policy.

Similarly, authorities seeking to more effectively regulate the physical availability of alcohol face a number of challenges. Returning to conditions in which alcohol could only be purchased from state-run off licenses, as was the case until relatively recently in a number of Scandinavian countries (and is an approach regarded by Babor *et al* (2003) as being 'strongly effective') is clearly a non-starter in a market economy framework. Even attempts to reduce hours/places of sale would run counter to prevailing trends in the majority of contexts including the UK. Taking this into account, stricter enforcement of existing regulations with respect to the sale of alcohol to those under the minimum purchase age (via merchant training, underage purchase attempts and qualitative engagement with underage drinkers) and persons already intoxicated (primarily by means of RBS) would perhaps offer the greatest potential to reduce consumption and associated harms. This is borne out by initiatives such as ARCAP, YATA, the STAD 'Stockholm beer campaign', Hawara Alcohol and Young People project, and the 'Think before you buy under 18s drink' project, all of which are reported to have achieved some notable results. However, ensuring the effective and sustainable enforcement of such campaigns is cited by a number of authors as posing a major challenge (Rehnman *et al*, 2005; Huckle *et al*, 2007; Clark, 2007).

The appropriateness and severity of sanctions imposed on establishments found to be in breach of licensing regulations in this regard would appear to be both a key consideration and an issue worthy of further exploration. One way in which it is suggested that

compliance could be enhanced is via greater use of civil liability laws¹⁰; this is reported by Goodliffe (2003) to be a current feature of US and Canadian licensing regimes.

Enforcement also has a key role to play with respect to interventions designed to reduce the incidence of drink-driving, which are positively evaluated by a number of authors (Voas, 2002; Holder *et al*, 2000; Room *et al*, 2005). However, such enforcement raises a number of important issues. Firstly, it is suggested that random breath testing is significantly more effective than ‘sobriety checkpoints’, particularly if carried out on a widespread scale. The stopping of motorists in certain Australian states for random breath testing, on average, 0.6 times a year is cited as providing supporting evidence of this (Babor *et al*, 2003, cited in Room *et al*, 2005). Whether this level of enforcement is possible in more densely populated European societies is questionable, together with political acceptability in terms of perceived impact on civil liberties. A reduction in the permitted BAC (blood alcohol content) in countries with higher tolerances, such as the UK, may offer a more pragmatic option, possibly along with graduated limits for young and/or newly-qualified drivers (Room *et al*, 2005).

Some contrasting perspectives can be noted with respect to the extent to which education-based interventions are regarded as being effective, or at least having a potentially important role to play as part of a broader ‘holistic’ approach. Of the three MCPs classified as conforming to the education-based typology considered in this review, one is very positively evaluated (SHAHRP – see Box 6), another is considered to have been partially successful (Project Northland Croatia – see Box 14) and a third (Project Northland Chicago – see Box 13) reported ‘not [being] effective in reducing alcohol use, drug use or any hypothesized mediating variables’ (Komro *et al*, 2008: 606). In many ways this reflects the views of some commentators who appear discernibly divided when assessing the merits of education-based approaches. For example, Babor *et al* (2003) are critical of school based education approaches:

‘School-based alcohol education strategies have been found to increase knowledge and change attitudes toward alcohol and other substances, but actual substance use remains unaffected. Approaches that address values clarification, self-esteem, general social skills and ‘alternative’ approaches that provide activities inconsistent with alcohol use (e.g. sports) are equally ineffective... in sum, the impact of education and persuasion programmes tends to be small, at best. When positive effects are found, they do not persist’ (p. 1347)

¹⁰ Civil liability laws enable the establishment/ individual serving alcohol to an underage or intoxicated person to be held at least partially responsible for alcohol-related damage or injury caused by that individual.

In contrast, others, such as Holder *et al* (2000), offer a more nuanced assessment by commenting:

‘Whereas education and public awareness campaigns alone are unlikely to reduce alcohol-related death in communities, when they are combined with the environmental strategies tested in this trial [California/Carolina project to reduce alcohol-related motor vehicle injuries and assaults], mutually reinforcing preventive interventions can succeed’ (p. 2347)

The above quote offers a worthwhile insight into how education-based initiatives are unlikely to succeed as stand-alone projects but can be employed to enhance prevention efforts and how components or initiatives can be combined to create project synergy. It also poses the question of whether education-based approaches might be more effective in the context of interventions aimed at harm minimisation as opposed to those advocating abstinence. The claim made by McBride *et al*, (2004) that ‘classroom strategies offer the greatest opportunity to impact on young people’ is, on the basis of the reported success of the SHAHRP initiative, a contention that should be considered. More generally, education-based approaches would seem to offer greater potential than suggested by critics such as Babor *et al* (2003), but as part of a more comprehensive programme in combination with other mutually reinforcing interventions.

In considering the survey and information based projects, a number of them reported positive outcomes (Heads UP!; My Student Body; Web-based self help for problem drinkers). These interventions offer the possibility of delivering individually-tailored advice and information to a specific target group in a highly cost effective way (online). This type of intervention, popular among participants because of the privacy offered, was described as being well-suited to the US college student population five years ago (when levels of internet access across the general population were lower) and could now perhaps offer the potential to be deployed among other target groups. In seeking to identify promising approaches, it appears worthy of further exploration.

3.7 Transferability: challenges and opportunities

The extent to which successful interventions might be transferable from one context to another is a key question for this review. However, there is relatively little evidence-based comment in the literature about interventions that have been deployed across a number of cultural/socio-economic contexts. A notable exception to this, however, is Project Northland, which has been implemented in both Chicago and Croatia (see Boxes 13 and 14 overleaf for information about these projects).

Box 13: The challenges of MCP transferability: Project Northland Chicago

Aim: to test the effectiveness of an education-based MCP developed for use with rural communities in Minnesota when applied to an urban, low income, ethnically diverse area of Chicago.

Background: The initial Project Northland (Minnesota) was developed to address issues associated with heavy and problematic use of alcohol by young people, a problem seen as difficult to address 'because alcohol use is so ingrained and acceptable in US culture' (Komro *et al*, 2008: 606). The original MCP was successful in achieving reductions in alcohol use and was identified as a 'model program' by the Substance Abuse and Mental Health Services Administration for transfer to other localities in the US.

Components: the project comprised:

- Peer-led classroom activities
- Parent/child activities
- Community-based education activities
- Underage purchase attempts/merchant pledges

Survey and results: Alcohol use, related risk and protective factors were measured via classroom-based surveys and underage purchase attempts monitored. At baseline alcohol use was slightly lower in the intervention schools. Across the three follow-ups there 'were no statistically significant differences in the growth rate of alcohol use and alcohol intentions scales between the intervention and control groups... the ability to purchase alcohol by young-appearing buyers was reduced in the intervention communities compared to the control communities, but this could have been due to chance' (Komro *et al*, 2008: 613 & 606). Secondary analysis employed to assess the effects of the different programme components showed the parent/child activities component to have returned 'promising' results).

Conclusions: Komro *et al* assert that the lack of success of the program can, in part at least, be explained by the 'challenges to organising around alcohol issues within inner-city communities including competition with other pressing issues (e.g. housing, gang violence), low acceptance of the importance of the issue and [lack of] resident time' (p. 613). The authors acknowledge the need to 'rethink how we conduct research in low income communities, to more fully engage these communities' (p. 615).

Box 14: The challenges of MCP transferability: Project Northland Croatia

Aim: To evaluate the effectiveness of a Croatian school-based alcohol prevention intervention based on the Project Northlands model. The intervention encouraged parent/child and peer-based interactions around alcohol-related topics. In contrast to the Chicago MCP, pupils commenced involvement at 10 years old. A significant subsidiary objective was to gauge how effectively the intervention would transfer to the different Croatian cultural context.

Background: Following independence (and the conclusion of the Balkan wars) the Croatian public health system was restructured in accordance with the principles of a social market economy. Preventative and proactive care strategies were de-emphasised and there was concern that adolescent exposure to traumatic events and high levels of unemployment would result in increases in various 'risk taking behaviour' including alcohol use (West *et al*, 2008).

Components: In contrast to the Chicago model (see Box 6 above), Project Northland Croatia was an exclusively education-based intervention. As well as receiving considerable media attention it comprised the following components:

- Homed-based parent and child activities
- Peer-led class activities
- Teacher-led activities
- Engagement with local communities and politicians

Survey and results: Students' alcohol-related knowledge, attitudes and behaviours were measured at baseline and follow-up. Intervention schools reported a slightly slower rate of increase for the 'tendency to use alcohol' measure (particularly amongst girls) than controls. Evaluation measures found that 'PN [Croatia] had an effect of delaying alcohol use in the early years but not in [the] later years... and that the intervention was more successful in changing the attitudes in the first and second years of the curriculum, but had less of an impact on older students' (p. 69). Qualitative findings indicated that 'many parents commented that their children placed pressure on them not to drink' as well as making 'them feel more reluctant to drink in front of their children' and that some students reported feeling 'empowered' by the intervention to be able to challenge school and government alcohol policies (p. 66 & 68).

Conclusions: West *et al* (2008) reported that the 'study provided a unique opportunity to work with a post-war country attempting to re-establish a previously strong public health infrastructure' (p. 68). A number of factors were identified as contributing to the project's 'limited success'. These included: strong stakeholder support, extensive media coverage and the building of effective partner networks. It was felt these factors had assisted the project in overcoming the various 'cultural adaptation challenges' inherent in the transfer of the MCP.

Because it demonstrated successful impacts in Minnesota, US, Project Northland was identified as a model programme with the potential of being transferred to other US locations. Its transference and adaptation to other locations both within and outside the US (Chicago and Croatia) provides a unique opportunity to examine the effects of transferring a programme and its implementation in different contexts. Box 15 below summarises the outcomes of transferring Project Northlands (Minnesota) to Chicago and Croatia:

Box 15: The effects of transferring Project Northlands to Chicago and Croatia

- Chicago MCP – no significant effect on behaviours or intentions found compared with Croatia MCP which reports positive and limited effects on students in early years only
- Possible reasons for ineffectiveness of Chicago MCP focus on challenges of developing alcohol interventions in inner-city communities - greater understanding of low-income communities needed i.e. local cultural context to fully engage communities
- Croatian MCP may have been more effective among older students had intervention started much earlier and had run for longer.

The Chicago MCP was found to have no significant effect on the behaviours or intentions of intervention communities compared with the Croatian MCP which reported both positive and limited effects; it changed attitudes and delayed alcohol use in early years but had little effect on students in their later years. Remembering that Project Northland was originally developed for use in rural communities, Komro *et al* (2008) suggest that the lack of success of the program in Chicago can, in part, be explained by the ‘challenges to organising around alcohol issues within inner-city communities including competition with other pressing issues (e.g. housing, gang violence), low acceptance of the importance of the issue and [lack of] resident time’ (p. 613). The authors acknowledge the need to ‘rethink how we conduct research in low income communities, to more fully engage these communities’ (p. 615). Both of these are salient points in the context of attempts to transfer initiatives that had delivered success in one locale to another with sharply contrasting socio-environmental characteristics. A further point worthy of note, and a commonality with the Croatian MCP, can be derived from the suggestion that perhaps the intervention would have benefited from starting while children were younger and running for a longer period.

Box 16: What can be learned from transferring MCPs?

- To assess how robust successful interventions are in different contexts and over different time periods
- To help understand processes involved in different cultural and policy contexts
- To help understand the processes involved in sustaining the effects of MCPs
- To better understand how components work together i.e. synergistic effects of components

Transferring MCPs from one context to another provides the opportunity for greater understanding of important processes and lessons learned from transferring MCPs are summarised in Box 16 above.

Beyond the Project Northlands examples, comment is largely divided. Some authors are cautious about the challenges of transferability and stress the need for ‘culturally appropriate implementation’ and ‘community consultation’ (Kypri *et al*, 2005: 19). Others suggest that transferability provides a way of mainstreaming best practice of interventions

that show success while providing opportunities to develop greater understanding of important MCP processes such as sustainability and component complementarity or synergistic effects:

‘Replication of our study is still necessary to establish the robustness of the results we have obtained and to assess how the observed effectiveness is observed over time’ (Riper *et al*, 2007: 223)

‘A critical question is whether this programme can be implemented in other cultural contexts. In Sweden, it is illegal for those under 20 years of age to buy alcohol and for those under 18 to drink in restaurants. This is roughly similar to North American, but in Europe countries such as the Netherlands laws against alcohol use either do not exist or are not enforced. Recent studies conducted in the Netherlands suggest that many parents do have strict attitudes, however, and they do influence youth drinking. Nevertheless, it is an empirical question whether this [the Orebro Prevention] programme would work in countries with weak restrictions on youth drinking. The programme seems promising, but replications in the same and different cultural contexts are needed’ (Koutakis *et al*, 2008: 1636).

On this basis, and drawing on the Project Northland Chicago and Croatia examples, it appears that gaining an understanding of contextual factors such as cultural norms and contexts as well as local policy contexts are key factors in developing MCPs, and that obtaining ‘buy in’ of key stakeholders and media coverage are also likely to encourage more successful transferring of projects. In practical terms, this is likely to require steering group formation and a comprehensive community mobilisation strategy. In other words, an intervention has a greater chance of success if popular support for the measures that are to be employed can be secured (Babor *et al*, 2003).

3.8 Conclusions

Examining project evaluations in the MCP literature together with emerging themes provides an evidence-based means of identifying promising approaches and initiatives. The following are identified as enhancing the success of an MCP:

- A clear rationale for developing and implementing an intervention is required.
- Securing effective ‘buy-in’ of stakeholders and relevant communities appears to enhance an MCPs success. Local communities require consultation particularly at the design stage of an MCP and a comprehensive community mobilisation strategy involving steering group formation is needed throughout the lifespan of the project.

- Developing clearly focussed objectives rather than more general aims is advised e.g. rather than aiming to reduce overall alcohol consumption, targeting a specific age or social group enhances potential project effectiveness.
- Initiatives need to be sensitive to the local cultural context.
- Projects need to be adequately resourced e.g. funding and staffing.
- The medium to long term sustainability of an intervention should be considered.
- Appropriate and adequate outcome measures need to be identified so that components can be evaluated e.g. multiple outcome measures offer the possibility to better understand the contribution of different components
- Evaluation needs to be built in at the design stage of an MCP
- Practitioners', stakeholders and community members' accounts in delivering interventions are important to understand how interventions are being delivered and received by target populations; these accounts may help to explain synergistic effects

The literature supports those commentators who suggest that the following represent the most effective interventions:

- pricing and taxation mechanisms, although political acceptability and industry opposition are recognised as significant obstacles to government action
- regulating the physical availability of alcohol, in particular to those under minimum purchase age and persons already intoxicated appears to offer the greatest potential, but the sustainable enforcement of this type of intervention represents a significant challenge.
- modifications to the environment or context in which alcohol is consumed or sold;
- drink-drive counter measures using widespread random breath testing but this type of enforcement may not transfer to densely populated European contexts and may not be politically acceptable. A reduction in permitted blood alcohol content may be more acceptable with gradations for young/newly qualified drivers.

In contrast, commentators are divided on the effectiveness of education, promotional and 'persuasion' interventions. While knowledge and attitude change towards alcohol have been recorded, actual use has remained relatively unaffected and effects are not found to persist. Education initiatives appear to offer most potential not as stand-alone projects but as part of a more comprehensive programme when combined with other mutually reinforcing interventions that can be combined to create project synergy.

Case study: Developing an MCP- Community Action Blackburn, Scotland (Changing Attitudes to Alcohol) 2008-2011

Chapter 2 examined in detail the MCP approach, highlighting the challenges faced in both carrying out and evaluating MCPs and gave examples of MCPs which have been delivered in the UK and internationally. Within this study we found just one example of an MCP; the scarcity of MCPs is probably largely down to the costs and complexity of mounting such programmes. Community Action Blackburn (Changing Attitudes to Alcohol) was a pilot project in Scotland, funded by the Robertson Trust and managed by Alcohol Focus, Scotland for the period 2008-2011. As its name suggests, Community Action Blackburn (CAB) took a community action approach and this section will briefly outline the project, how it evolved during the course of the pilot and the plans to take CAB forward. This section draws on the final evaluation report (Plunkett and Bryceland, 2011) which is available at:

<http://www.alcohol-focus-scotland.org.uk/view/article/73-community-action-blackburn-final-report> .

Background

Blackburn, West Lothian is a small town (population approximately 5500 people), situated about 20 miles from Edinburgh along the old M8 towards Glasgow.
(<http://www.blackburnwestlothian.co.uk/>, accessed 16th March 2011).

Blackburn was chosen after a scoping exercise which considered 32 communities in Scotland as possible sites, the basic criteria for selection were:

- Broad socio-economic mix (used data from Index of Multiple Deprivation)
- Defined community - with a definitive boundary
- Population of no more than 60,000

Other contextual factors including crime, provision of primary care, community structures were taken into account in making the final choice.

Aims

The overall aim of the project was to change social and culture community norms around alcohol, taking a whole community approach.

Sustainability was an important element and three key mechanisms were identified:

- Institutionalisation
- Partnership working
- Community interaction, involvement and ownership

Evaluation was also integral to the design of the project. Community ownership of the

project was identified as fundamental to sustaining changes beyond the life of the project and underpinned the design of the project: the community needed to decide what the issues were for that community and how they wanted to deal with them. Community Action Blackburn was originally called 'Alcohol Action Blackburn'; however, initial consultation by the project officers with the community encountered a reluctance to engage with an alcohol project (Wright, 2011, p.21). The Steering Group which included community members and key local stakeholders suggested that a name change was required - Community Action Blackburn was 'born' and consultations resumed. The community consultation involved gathering the views of members of the community and key local stakeholders through interviews and questionnaires and also a school project. The change of name had an immediate positive impact with the community actively engaging with the project, identifying issues of concern (e.g. anti-social behaviour) and expressing strong desire to reduce alcohol related harm in their community. Charlie Bryceland, Community Project Officer, attributed this change to the removal of 'alcohol' from the project name (Wright, 2011, p.21).

The community identified three specific short to medium priorities:

Priority 1: **Building capacity** in the community through community engagement, communication as well as enhancing interagency links

Priority 2: **Addressing the clear alcohol issues** in relation to alcohol availability within the community and alcohol education

Priority 3: **Enhancing access and availability to local facilities** (Plunkett and Bryceland, 2011, p. 18).

The activities of the pilot project were focused on addressing these three priorities and developed organically during the course of the pilot.

Target group

The whole community of Blackburn

Outcomes: working towards long term change

A number of outcomes were identified (see Box 17) and the Steering Group developed a work plan and a number of sub-groups were established to take the plan forward.

Box 17: CAB outcomes:

- Decrease ease of access to alcohol within the community
- Delayed average age of first use of alcohol
- Reduction in number of alcohol related incidents within the community
- Improvement in health and wellbeing of the community in relation to alcohol

It was recognised that bringing about cultural change within a community and encouraging more responsible attitudes to drinking and alcohol related behaviour were unlikely to be achieved during the life of a 3 year pilot project – they are long term outcomes. There was an understanding that a series of short and medium term changes would be required in order to achieve these long term outcomes. In addition, factors outside the CAB (e.g. change in local or national policy) may influence the outcomes and these need to be recognised and examined.

The CAB project is developing its own logic model approach to demonstrate the impact and outcomes of the work progressed so far (Plunkett and Bryceland, 2011). Graham (2011) argues that both interventions and evaluations benefit from using explicit logic models that identify the process by which the intervention is expected to work and distinguish between measures of implementation, mediation and outcomes.

Plunkett and Bryceland (2011) argue that it is possible to demonstrate impact in relation to the three priorities of the pilot project:

Building capacity: CAB has moved from “nothing to an entity that can show a vast range of community engagement and communication (Plunkett and Bryceland, 2011, p. 45). The profile of alcohol has been raised substantially with the delivery of showcase events, development of sub-groups, promotional activities e.g. community newsletters, directory of services, creation of community website

(http://www.blackburnwestlothian.co.uk/groups_view.php?id=3).

Furthermore this engagement has produced action in relation to the other two priorities

Addressing alcohol issues in the community;

- 1) Developing an integrated alcohol education awareness programme. A broad range of school based activities was undertaken, which encompassed not just children/young people but also their families, broader community and a range of stakeholders (e.g. police, health professionals). School based activities included education programmes for all ages (starting with 3-5 year olds), primary school conferences for children in P7 (Primary 7, age 11-12) where the children reported to the stakeholders, exhibition of children’s work at a local shopping centre and a writer working with young people. A number of activities and actions arose from the 2009 P7 conference (see Box 24) and the children were instrumental in initiating and driving these forward.
- 2) Tackling availability and access to alcohol within the locality. A key development was the ‘Can’t Tell Won’t Sell’ initiative which has involved CAB working with licensees, community, statutory and voluntary agencies to produce a package to reduce the incidents of underage and agent purchasing and also alcohol related anti-social behaviour. The initiative included a proof of age scheme, training programme for staff working in licensed premises, police enforcement, widespread publicity about the initiative.

Enhancing access and availability to local facilities: CAB has been instrumental in arranging community clean ups, the erection of community notice boards in the shopping centre, bringing forward the planned upgrade of the local park and securing funding for new activities for young people (see Box XX) and for a community mural.

Box 24: Activities and actions which arose from the 2009 P7 primary school conference

Establishment of an *Action Group* which focused on community clean-up programmes, an underage agent purchasing and selling initiative and secured funding for a community mural.

Social responsibility programme for P6 and P7 children (aged 10-12) facilitated by West Lothian Youth Action Project Peer Educators. Activities included the children developing their own local community conference held in 2010 where they reported to stakeholders and the conference report which highlighted the children's concerns about the availability and accessibility of alcohol, drugs and cigarettes was sent to Members of the Scottish Parliament.

Blackburn Youth Forum: activities included youth consultation on why young people do not access the services within the community centre and specific actions to address the issues raised; successful application for funding to develop new activities for the young people of Blackburn.

The children and young people have won recognition of the work they have undertaken:

- 2010: Mentor UK Champs Award: Highly Commended.
- 2010: Children and Young People Now Awards: shortlisted from over 500 projects for the health and well being category.
- 2010: Voluntary Sector Gateway West Lothian Volunteer awards: Highly commended in the Active Citizenship category
- 2010: West Lothian Stellar Awards: Stellar Citizenship Award

Plunkett and Bryceland (2011) examined crime data to assess the impact of the CAB on levels of anti-social behaviour and alcohol related crime. Within the CAB crime data is one of the only local data sources available as a baseline to show impact, however, the numbers are small and caution is required when interpreting them. From the limited data available it appears that there has been some reduction in alcohol related incidents and alcohol related youth calls (e.g. reports of underage drinking, attempts to purchase) (Plunkett and Bryceland, 2011). As part of the evaluation *a survey of local stakeholders* was conducted to gather the perceptions of the impact of the work of CAB and a small *sample of community representatives was interviewed*. (Plunkett and Bryceland, 2011).

Both the stakeholders and community representatives felt that:

- Alcohol was now viewed as a local priority by both the community and local

organisations/services.

- Communication across professional and community channels had improved.
- There was more partnership working in relation to alcohol issues.
- There were early indications that Blackburn was starting to see an impact, for example on visible alcohol related disorder.

However, community representatives felt that further work was needed in relation to the development of and access to local facilities.

The work undertaken to date has been only been possible because the CAB project, over the course of eighteen months, secured almost £100,000 additional funding (the funding from the Robertson Trust was to provide project worker support) from a variety of sources including the West Lothian council, Drinkaware Trust and West Lothian Health Improvement Team (Plunkett and Bryceland, 2011, p. 41). Furthermore, West Lothian council has committed £42, 000 per annum funding to continue the CAB project (Plunkett and Bryceland, 2011, p. 43).

Development of outcome measures

Plunkett and Bryceland (2011) argue that CAB needs to develop a range of indicators that are able to demonstrate the overall impact of the work as it progresses from the pilot stage. To enable the measurement within Blackburn of the nature and perception of drinking within the community Plunkett and Bryceland (2011) suggest conducting drinking surveys and public perceptions surveys within the local population in order to develop a Community Alcohol Profile. The further development of a logic model is integral to the measurement of impact.

Evaluation

Evaluation was integral to the design of the MCP and the final report, which this section draws upon, was published in May/June 2011 (Plunkett and Byrceland, 2011).

Lessons learned

The key lesson is the *importance of direct engagement with the community and its representatives*: as Clancy Wright (2011) observed, a key lesson from the Community Action Blackburn project is that by taking ‘alcohol’ out of the debate, encouraging the community to broaden out the issues of concern, the community can then ‘join the dots’ and embrace alcohol interventions as part of a broader approach to addressing community issues.

Sustainability

The pilot project ended in February 2011, and the Steering Group decided to investigate the possibility of taking on charitable status and ways of sustaining the achievements of the project. Community Action Blackburn (Changing Attitudes to Alcohol) is now a community owned entity in its own right having been granted company and charitable status (Plunkett

and Bryceland, 2011, p. 66). As noted above, core funding has been secured and these two developments are crucial steps in the process of institutionalising change.

Transferability

Alcohol Focus Scotland is launching the National Communities Project in Spring 2012. The project aims to work with two communities to take learning from CAB and other areas of good practice, and apply the learning to these two new communities. The new communities will have their own priorities that they will wish to address and the project's job is to support these communities. In addition, the project aims to collate and communicate a national evidence base on best practice and develop a one-stop shop for information to assist in addressing alcohol-related harm in communities. For more information visit

<http://www.alcohol-focus-scotland.org.uk/national-communities-project>

Summary

CAB is a clear example of the early stages of a community action MCP. CAB has been able to demonstrate short term changes which provide a platform for longer term, sustainable changes. This case study highlights:

- the importance and value of community engagement in the development and a MCP
- the organic and evolving nature of a community action MCP
- the challenges of developing/identifying measurable outcomes to demonstrate impact

4. Learning from the field

This chapter will report the findings of the scoping exercise, which consisted of an email questionnaire to key informants, follow up interviews about specific promising initiative, a practitioner workshop and an examination of the HubCAPP database of local initiatives. Interventions delivered at local level are shaped by national and regional policy and so before considering the findings this section will set out the policy context, outlining key developments in alcohol policy during the latter years of the New Labour government (2004-2010). This study was conducted (June 2010 –Feb 2011) during a period of uncertainty and change triggered by a change in government and consequent review of policies by the Coalition government, which was reflected in our data, with respondents often unsure if ‘promising’ initiatives would continue.

4.1 The policy environment: key developments in alcohol policy 2004-2010

In 2004 the New Labour government published the long awaited national alcohol strategy *Alcohol Harm Reduction Strategy for England* (AHRSE) (PM Strategy Unit, 2004) which set out the policy framework for England and Wales. The strategy had four main strands: education and communication; identification and treatment; alcohol related crime and disorder; and supply and industry responsibility. The strategy emphasised that alcohol was a cross-cutting issue, but identified health and crime as the main areas where action was required and set in place ‘light-touch’ central arrangements, with the Home Office and the DH sharing a responsibility for delivery and working closely with other departments such as the Department for Culture, Media and Sport and the Department for Education and Skills. Local areas were given “flexibility for local partnerships to deliver what is needed in their area, whilst staying in line with the aims of the national strategy” (p.72).

The Licensing Act (UK Government, 2003), which came into force in November 2005, transferred the responsibility for licensing decisions to local authorities. The four licensing objectives, which underpin decision making are, the prevention of crime and disorder, the prevention of public nuisance, public safety and the protection of children from harm. The exclusion of a public health objective was criticised. The Act allowed for more flexible opening hours for both on-licence and off licence premises and looked towards the creation of a more cosmopolitan, ‘cafe’ style’ of drinking with the expectation that the changes would contribute to a reduction in alcohol-related harm. Claims that the new system could help to tackle alcohol-related harms were hotly contested, with critics arguing that the changes would lead to an *increase* in alcohol-related harm (e.g. Foster, 2003; Plant and Plant, 2005). Much of the debate revolved around the rationale and evidence for permitting 24-hour licensing (see Herring *et al*, 2008 for further discussion). In fact, few on-licence

premises opted for 24-hour licenses, with most increasing their usual opening hours by less than an hour a day (Hough *et al*, 2008). Early indications are that whilst some crime has been displaced to the small hours, overall there has been little change in the level of crimes associated with the night time economy and a small fall in the more serious crimes of violence (Babb, 2007; Hough *et al*, 2008).

Safe. Sensible. Social (HM Government, 2007b) which updated the AHRSE set out a more structured implementation framework for achieving a reduction in alcohol-related harms. Local Area Agreement (LAA) partnerships were identified as well placed to plan a comprehensive approach bringing together the various interests (e.g. crime, health, education) involved in tackling alcohol-related harms. Among other things, Government Offices for the Region (GORs) were required to support CDRPs (later to become Community Safety Partnerships) in the development and implementation of their strategies and in April 2008, all CDRPs were required by law to have a strategy to tackle crime, disorder and substance misuse (including alcohol-related disorder and misuse) in their area (2007b,p,7). From 2008, LAAs managed the central 'delivery contract' between central government and local government, to negotiate and oversee the setting of targets drawn from a National Indicator Set based on area priorities (which were not all related to alcohol). The performance framework for local authorities and local authority partnerships for the period 2008/9-2010/11 included, for the first time, a Public Service Agreement (PSA) related specifically to alcohol: PSA 25 stated 'reduction of the harm caused by alcohol and drugs' as the target (7b, 2007a). The National Indicator 39¹¹ (NI 39) was used to measure progress on this target: NI 39 measured the rate of alcohol related admissions per 100,000 population using Hospital Episode Statistics (HES)(HM Government, 2008) and the aim was to 'reduce the trend in the increase of alcohol related hospital admissions' (HM Government, 2008, p.67).

The NHS Operating Framework for the period 2008/9- 20010/11 included the equivalent of the NI 39 (Department of Health, 2008b). Vital Signs 26 (VSC26) measured "rate of hospital admissions for alcohol-related harm" (Department of Health/NHS, 2008) vital signs poster) and was included as one of the 'vital signs' for 'Improving health and reducing health inequalities' (a national priority area). VSC 26 was a tier 3 'vital sign', so an option that PCTs could choose in conjunction with local partners as a priority for 'local action', rather than a national priority for local delivery (Tier 2, e.g. numbers of drug users recorded as being in effective treatment) or a national requirement (Tier 1, e.g. rates of *Clostridium difficile* infection). The key difference is that for Tier 1 and 2 'vital signs' all PCTs had to set plans which were then signed off by the Strategic Health Authority (SHA) and performance managed (at least to some extent) by the DH¹², whilst Tier 3 were not. So whilst the

¹¹ NI 39 was introduced in 2008 and the definition of the indicator was revised in April 2009.

¹² Tier 1 vital signs were all centrally performance managed whilst, for Tier 2 a 'risk management' approach was taken and focussed on weak areas or organisations only (DH, 2008b, p.6).

inclusion of a specific alcohol 'vital sign' was welcomed by the field there was some disappointment that it was not identified as a 'national priority' for local delivery.

The Alcohol Improvement Programme

An important development was the Alcohol Improvement Programme (AIP), established in April 2008 by the Department of Health to help reduce the rate of alcohol-related hospital admissions. It was a three year programme (March 2008-March 2011) and like earlier Health Improvement Programmes (HIMP) it was linked to issues of tackling health inequalities and providing support to Primary Care Trusts in some of the more deprived communities. The AIP identified seven 'High Impact Changes' (HICs) and aimed to encourage implementation of evidence based interventions (such as identification and brief advice).

The 'High Impact Changes' are:

1. Work in partnership
2. Develop activities to control the impact of alcohol misuse in the community
3. Influence through advocacy
4. Improve the effectiveness and capacity of specialist treatment
5. Appoint an Alcohol Health Worker
6. Identification and Brief Advice (IBA) – Promote more help to encourage people to drink less
7. Amplify national social marketing priorities

Guidance on how to implement the HICS was contained in *Signs for Improvement: commissioning interventions to reduce alcohol-related harm* (DH, 2009). The guidance set out the rationale for each HIC , the evidence it 'works' and gave 'case study' examples to show how it had already been successfully implemented with the reader directed to HubCAPP for further information. A 'warning' was given to commissioners:

“The High Impact changes for alcohol presented in this document are linked. The temptation to see them as completely separate activities from each other would be the wrong approach. While changes 4 through 7 are supported by clear evidence of their impact, changes 1 through 3 are changes that set the scene for progress.” (DH, 2009, p.73)

Thus, there was an acknowledgement that 'stand alone' initiatives were less likely to succeed than a multi-component approach. Partnership working was identified as an essential foundation to reducing alcohol related harm and the DH argued it was unlikely that progress would be made without effective partnerships (DH, 2009, p.74). The need for all local partners – NHS, LAs, police, fire and rescue services – to use existing powers available to them to maximise impact on alcohol-related harm was highlighted in HIC Two.

In order to support areas to implement the HICs a number of mechanisms were put in place:

- *North West Public Observatory (NWPHO)* was commissioned to provide local alcohol profiles to assist PCTs and local authorities in needs assessment and developing appropriate responses. These profiles were made available on-line and regularly updated.
- *Regional Alcohol Managers (RAMs)* were appointed to provide linkage between different agencies to assure local delivery and performance monitoring, and provide regional and local advocacy and championing. There were nine RAMs, one for each Government Office for the Regions.
- *National Support Team Alcohol Harm Reduction (NST)* was established to support the NHS, LAs and partner organisations in areas with the highest rates of alcohol related hospital admissions to review their commissioning and delivery systems for alcohol harm reduction and identify what improvements could be made.
- *The Alcohol Learning Centre (ALC)*, an on-line 'one stop-shop', was launched in 2008 for frontline practitioners and commissioners. It contains alcohol specific policy documents, guidance and tools. In addition, the ALC provides training resources, for example, an IBA e-learning training course. Another key function is to disseminate learning and 'promising' practice from the NHS and Third Sector, e.g. provides named case examples and contact details of key personnel. The ALC can be accessed at: <http://www.alcohollearningcentre.org.uk/>
- *Early Implementer PCTs*, twenty PCTs¹³ with high levels of alcohol related admissions and health inequalities (they were all 'spearhead' areas¹⁴) became 'Early Implementers' (EIs). These areas were given additional support and financial resources to 'go further faster', with the aim of disseminating the learning from their practice to other areas through a number of forums including the ALC and HubCAPP. The support took a number of forms and was co-ordinated through the ALC including, national events and workshops organised by the DH, new bulletins and email alerting, eLearning, input from the RAMs and a NST visit.

Thus, the period 2008-2011 saw a focused period of activity, in relation to reducing alcohol-related hospital admissions, led by the DH and delivered regionally via the GORs and at local level by local partnerships

¹³ The PCTs were: Newcastle, Middlesbrough, Heart of Birmingham, Knowsley, Manchester, Ashton, Leigh and Wigan, Warrington, Leicester City, Nottingham, North Tyneside, Stoke-on-Trent, North Lincolnshire, South Birmingham, Newham, NE Lincolnshire Care Trust Plus, Bolton, East Lancashire, Darlington, Oldham and Blackpool.

¹⁴ The government made commitment to narrow the gap in health outcomes for the LA areas that are in the bottom fifth nationally for 3 or more of the following indicators: male life expectancy at birth; female life expectancy at birth; cancer mortality rate in under 75s; cardiovascular disease mortality rate in under 75s; average score on Index of Multiple Deprivation: these are the Spearhead areas.

4.2 The scoping study initiatives

We collected information on 26 initiatives from 19 people (with some reporting on 2 or 3 initiatives). We had examples from all regions of the UK except London.

The majority of initiatives (20) had begun between 2008-2011 with four pre-dating 2008 and over half (14) had been funded for a specific time period whilst the remaining (12) had continuous funding. Three projects had already ended.

Table 6 shows the various funding sources, this highlights the importance of health sector funding and also joint funding with multiple answers being given to this question.

Table 6: Sources of funding for the initiative

Funding source*	Number of initiatives
Health	24
Police	6
Multi-agency	6
Research project	1
Other e.g. Comic Relief	3

*Multiple answers possible

The vast majority (23) of these initiatives were alcohol specific, two addressed both alcohol and drugs and in one initiative alcohol was a component of a broader initiative.

Furthermore, they all focussed on a specific target group (e.g. young people, pregnant women, those 'at risk' of developing alcohol related health problems, etc) rather than the general population. These initiatives varied in focus (see Table 7) but health was the predominant focus, either solely or in combination with criminal justice issues.

Table 7: The focus of the initiative

Focus of initiative*	Number of initiatives
Health	16
Criminal justice	0
Combined health & criminal justice	10
Multi-agency approach	7
Industry based	0
Other	0

*Multiple answers possible

Origins and influences on the initiatives

The majority of the initiatives (21) arose in response to a specific local issue, for example, increasing A & E attendances and hospital admissions amongst young people, increasing alcohol-related violence and anti-social behaviour. In some instances, respondents cited a local needs assessment as providing 'evidence' of a problem, whilst in other cases 'awareness' amongst local professionals (e.g. police, health staff etc) was the driving force. Whilst national impetus was only recognised by one respondent, the issues addressed reflected national policy concerns i.e. underage drinking, increasing hospital admissions. Furthermore, some initiatives were clearly aimed at helping to contribute to meeting the NI 39 target of reducing the rate of alcohol admissions, for example, focusing on people who are repeatedly admitted to hospital because of their alcohol use and areas have adopted the High Impact Changes, e.g. IBA and alcohol health workers.

Table 8 summarises key dimensions of the initiatives. Nine of the initiatives were reported to be an entirely new approach, for example, a self help and alcohol awareness group in supported housing. One of the new approaches, which aimed to deliver community based treatment to adult offenders serving community sentences, whilst new to alcohol, followed and adapted a Home Office 'best practice' example for drug users. Fifteen of sixteen of the initiatives that were based on existing approaches reported basing them on 'best practice' examples' (in one case the respondent was unsure whether the initiative was based on a 'best practice example'). The best practice examples were mostly drawn from other local areas (see Table 9), with named examples often being given, but one was drawn from Australia. Other respondents had based the initiatives on examples provided by the Home Office and on the HubCAPP website.

Table 8: Key dimensions

	New approach	Evidence based	Best practice example	Adapted
Yes	9	17	16	13
No	16	6	7	12
Do not know	1	3	2	0
Total	26	26	25	25

Table 9: Sources of examples of 'best practice'

Source of best practice example	No. of responses*
Home Office	4
HubCAPP	2
Example used elsewhere	13
Total	17

*Table 8 shows that there were 16 initiatives based on 'best practice' examples, whilst in Table 9 the total is 17: this is because one respondent reported being 'unsure' if the initiative was based on a best practice example but then stated it was based on a Home Office best example.

Seventeen respondents stated that the initiative was evidence based. Perhaps not surprisingly, the six which were not evidence based, were all approaches which were being tried out for the first time. For two of the 'new' approaches, respondents reported that they were evidence based, with one stating that they had gathered evidence from different sources including the literature and experts. Whilst in the case of one of the 'new' approaches, the respondent was unsure whether the initiative was evidence based or not. Thirteen of initiatives had been adapted for a variety of reasons. For example, to meet the needs of the local community, different administrative systems or the target group:

"The way that data were recorded in the hospital was different from that of (*name of hospital*), so the protocols had to be developed accordingly to access the data" (04/1)

"The Community alcohol team examined the needs for alcohol users as it was being adapted from the example for drug users to alcohol users". (17/1)

Respondents did not report any significant problems with adapting initiatives or any unintended consequences. On the contrary the adaptations were regarded as successful:

"Very positive. There were no problems in developing the protocols". (04/1)

"Very positive. There were no problems in adapting. No drink diaries were kept in prison obviously as they were in initiative 1". (17/3)

"The adapted programme has been successful".(17/1)

Determining 'success (Evaluation)

The majority (17) of initiatives had been or were being evaluated, in six cases the evaluation was by an external agency, but for most initiatives (10) the evaluation was internal. For one initiative, although an evaluation was planned it had not been decided who would conduct it. Interestingly, for two initiatives which had not been evaluated the respondent reported that routinely collected data (e.g. PCT, police, local authority) indicated the initiative was successful:

'By looking at data from partners it is clear that street drinking is decreasing'. (23/3)

'Monthly and quarterly data from Police, DAAT and local councils show that violence is decreasing.' (23/1)

In terms of outcome measures, a variety of answers were given but evaluation generally included attempts to demonstrate effectiveness (e.g. reduction in arrest for alcohol-related crimes, reduction in alcohol related A&E attendances, changes in drinking behaviour, changes in knowledge) and also to consider costs (see Table 10). For example in relation to a

multi-component programme aimed at reducing alcohol misuse and alcohol-related violence in a town centre:

‘The Team has looked at partnership working with the police, the impact on A&Es (reduction of alcohol-related A&E attendances), the number of referrals made to agencies by the alcohol referral worker. The results are good’. (09/1)

Table 10: Outcome measures

Outcome measure	Number of responses*
Effectiveness (e.g. clinical, statistical data)	10
Cost	5
Other measures	7
Not yet decided	1

*Multiple answers are possible

Respondents felt that they had evidence of success, for example:

‘Pre and post interventions providing information/education have been compared. It has been shown that schoolchildren’s and teachers’ knowledge on alcohol has increased’. (07/1)

‘The (external agency) has carried out costing evaluation as well as sobriety periods. Half the group has been alcohol free for several months. The (external agency) is pleased about the progress of the group’. (08/1)

Award schemes

There are national, regional and local award schemes to recognise and promote good practice in health, social care and criminal justice settings. Whilst some schemes are alcohol specific, for example, the Mentor UK Champ Awards¹⁵ (for alcohol misuse prevention projects), others have a broader remit but include alcohol, such as the Home Office Tilley Awards¹⁶ which recognise innovative projects that involve the police, community organisations and the public working together to address crime at the local level. Such schemes can be seen as ‘markers’ of promise, as they require some form of evidence of impact. Two initiatives had won awards:

- The Cleveland Arrest Referral Service won “Partnership of Year”, Cleveland Local Justice awards in 2009 (14/1), click on link <http://lcjb.cjsonline.gov.uk/Cleveland/3695.html>.
- Durham Community Alcohol Service's Alcohol Rolling Programme which provides structured day structured day care in community locations to both offenders and non-offenders with alcohol misuse problems won the North East Prison Aftercare

¹⁵ For more information see <http://www.mentorfoundation.org/projects.php?id=102>

¹⁶ For more information see <http://www.homeoffice.gov.uk/crime/partnerships/tilley-awards-2011/about-awards/>

Society's (NEPAC) award in 2009. See link for further details
<http://www.nepacs.co.uk/awards> (accessed 08/03/11)

And another initiative to deliver IBA in A&E departments to all adults presenting with an alcohol related problem or injury had been based on the award winning Paddington model: the Alcohol Health Work project based at St Mary's Hospital, Paddington won the HubCAPP Project of the Year award 2009 (Alcohol Concern, 2010).

Looking to the future: sustainability and transferability

In relation to the sustainability of initiatives, a positive evaluation was regarded as crucial:

'It depends on the results of the evaluation and the cost.' (12/2)

'Yes it is (sustainable). Schools have been cooperating, the results are positive, and depending on the review and the evaluation in March 2012, it may well continue.'
(07/1)

However, as these quotes indicate, even with a positive evaluation there remains a degree of uncertainty. The public spending cuts mean that costs, always a key consideration are currently of even greater importance:

'It is sustainable as long as the partnerships can continue funding. So it is not certain.' (23/3)

'It is sustainable as long as funding is available.'
' (02/1)

'It is sustainable. The scheme is cost effective as the unit cost of an intervention is £50.08. Also the partners are committed to the scheme.' (14/1)

'It is sustainable as the A&E staff have been cooperative and the cost is very little.'
(28/2)

However, several participants at the workshop commented that as local bodies seek ways to deliver services with limited resources this has led to a questioning of 'usual business' and may open up opportunities for new promising initiatives that can demonstrate their 'value'. For example, a three month pilot project, targeting 'frequent flyers' – those people with the highest readmissions rates – in Portsmouth was estimated to have saved an estimated £21,000 (including the cost of the worker) and the pilot was extended until July 2011 (see Chapter 6 for further details).

Looking to the future, for many respondents a key issue was securing funding to enable the initiative to continue and some had been successful, for example, an initiative to offer treatment as an alternative to a custodial sentence which was funded initially for two years by the local authority but from April 20011 the PCT will take over the project from April 2011, the contract rewritten and the project will be a statutory requirement.

Respondents were also hoping to transfer the initiative to other areas, refine the initiative or to try the intervention with a different target group:

“The next steps would be to extend the initiative to other areas in the county and help other counties develop this kind of campaign; there is already interest from other counties.” (06/1)

“The next step is to introduce a mental health assessment into the scheme as quite a number of those arrested for alcohol or drugs have mental health issues. (Name) is working to introduce this assessment.” (14/1)

“Currently the PCT is discussing whether to spend the pot of money for alcohol training with a different group. “ (27/2)

In some cases, changes were being made to mainstream practice:

“The next step would be to improve the hospital data, the way that information about the patients is recorded. “(04/1)

“To develop better aftercare services for women.”(17/2)

Maclea *et al* (2010) in a study of project implementation and sustainability of alcohol and other drug projects in Australia found that embedding changes into the organisations operational processes or policy was a key factor in sustaining a project in the longer term.

4.3 HubCAPP database of local initiatives

The Hub of Commissioned Alcohol Projects and Policies (HubCAPP) was an online resource of local alcohol initiatives throughout England and Wales (from 2009). HubCAPP was established in 2008 to assist people working in the alcohol and health field:

- “Promote and highlight their projects and local strategies
- Share practice examples and details about initiatives in their area
- Learn from others to reduce duplication” (Ward, 2010, p.2).

From its launch in March 2008 until September 2010 HubCAPP was managed by Alcohol Concern, but this responsibility has now been passed to the Alcohol Learning Centre (ALC), who now host the database of ‘Local Initiative’s which can accessed and searched at the ALC <http://www.alcohollearningcentre.org.uk/>). There were 169 projects live on the website when it transferred to the ALC.

HubCAPP comprised a small team who collated and researched projects. Projects were suggested by third parties, self-submitted by the project or identified through press clippings, proceedings of conferences etc. The HubCAPP team then worked with project staff to collate information about the project, including its aims and objectives, its background and origins, funding, challenges (and how they were overcome), costs and any evaluation. Initiatives were categorised by region and also as to whether they fell into one of the Department of Health priorities:

- Health projects involving GPS, ambulance services, pharmacists, nurses, or those that occurring health setting e.g. hospital
- Young people
- Alcohol Arrest Referral Schemes
- Treatment care pathways and services design
- IBA
- Community projects led by community groups or those that occur in a community setting.

In some cases, initiatives fell into more than one category, for example, Project 28 Alcohol and Sexual Health (ASH) project in Bath, was a health project delivered to young people.

Once collated the information was made available via the HubCAPP website and e-bulletins (e.g. Alcohol Learning Centre e-newsletter, Alcohol Concern news). In addition a briefing paper was produced which presented information from a range of initiatives included on HubCAPP and the learning from them (Ward, 2010). As noted above two respondents reported basing their initiative on a HubCAPP example, and it is not unreasonable to speculate that some of the 13 which had been ‘tried in other areas’ also feature on HubCAPP. In November 2009 the HubCAPP awards were launched, with the winners being announced in March 2010. The Alcohol Health Work project St Mary’s Hospital, Paddington won the ‘HubCAPP Project of the Year’ 2009 award: “St Mary’s won the award for their innovative and longstanding work using Alcohol Nurse Specialists to quickly screen and tackle those presenting with an alcohol problem” (Alcohol Concern, 2010). ‘Stoke-on-Trent’s Commissioning capacity in alcohol treatment’ won the ‘HubCAPP Most Useful Project of the Year’ 2009 award” Stoke won their award for a comprehensive, thorough and needs led review of specialist alcohol treatment and a comprehensive implementation plan to meet demand on overstretched services” (Alcohol Concern, 2010).

The projects contained in the HubCAPP database whilst broad ranging in their scope and nature, however, given the DH funding of the work, strongly oriented towards health projects. Furthermore, they reflect the national policy context of the period 2007-mid 2010, (i.e. the policies of the previous New Labour government) and in particular the HICs. In addition, Early Implementer PCTs are strongly represented as they were encouraged to submit at least one project to HubCAPP in order to share their learning with other PCTs. Interestingly, only one of the projects on HubCAPP uses the term and could be classified as a multi-component programme (MCP): Aquarius *Route 50* project in Birmingham that was one of UKCAPP demonstration projects funded by the AERC (see Mistral *et al*, 2007).

4.4 Factors enabling/hindering success

Three key factors that enabled or hindered success can be identified. These factors overlap and interrelate but have been separated here for the purposes of clarity:

- Engagement and commitment of key individuals
- Context and 'conditions'
- Funding

Engagement and commitment of key individuals

A factor that emerged as significant in the success or otherwise of an initiative was the engagement and commitment of the staff involved in the delivery of the initiative and also the wider partners:

"The project is sustainable as there is no problem about costing and there is excellent cooperation between the police and the Young Peoples Drug & Alcohol Service." (05/2)

"It is sustainable as the agencies involved are all eager to carry on with the campaign. Other counties are showing interest in this campaign to carry it out in their own areas." (06/1)

This finding is consistent with recent research exploring partnership working as a mechanism for reducing alcohol related harm at the local level (Thom *et al*, 2011). Related to this is the need to recruit and retain appropriate staff to deliver initiatives. In some instances lack of cooperation led to difficulties:

"Not sure (*if initiative is sustainable*); if pharmacies cooperate more and are more motivated, it may be sustained." (28/1)

"Not at the moment as it has stopped. In the future if it starts again, it would only be sustainable if hospital staff could be more cooperative or if the hospital gives more freedom to the workers to look at the data themselves." (29/1)

The initiative referred to in the last quote was stopped as hospital staff made so few referrals of the target group to the alcohol health workers (AHWs). The problem was compounded by the fact that the AHWs were employed via an agency and hospital policy about confidentiality meant that the AHWs were not able to access the data themselves to identify individuals. These findings echo those of other studies (e.g. Peters *et al*, 1998; Thom *et al*, 1999; Maclean *et al*, 2010) and highlight the importance of having staff 'on board' because without the co-operation and support of key individuals the initiative will face difficulties and may ultimately fail.

Context and 'conditions'

What emerged clearly was the importance of the broader context on the success or otherwise of an initiative. Some local areas have a longer tradition to responding to alcohol related harm than others and this is reflected in the policies and structures in place to tackle alcohol related harm. For example, in relation to the 'Cardiff model', a workshop participant

suggested that in order to implement the Cardiff model a town needed to be at a certain level of sophistication in relation to strategic information gathering. Furthermore, respondents recognised that what worked in one area may not necessarily work in another or that adaptations might be required:

“The communities are different. In each town there were different problems to tackle. So it was not possible to simply follow what was done in Town A. For instance, in Town B there was a need to do more night time patrols”. (23/1)

There were examples of initiatives that had been adapted to meet local needs. For example, in a rural area, concerns about under age street drinking and young people being unnecessarily criminalised (because of being found in possession of alcohol) a referral system has been established. If a young person is found in possession of alcohol for a second time, parents are visited at home, information on alcohol and alcohol related problems is provided to the young person and their parents, and, following a needs assessment the young person may be referred to the Young Peoples’ Drug and Alcohol Service. The project offers voluntary engagement to the referral system, but if the young person refuses to go then prosecution would follow. The project is funded and delivered by the local Young Peoples’ Drug and Alcohol Service in partnership with the police. It is hoped to extend the schemes to surrounding urban areas.

There can be pressures on local decision makers to ‘do something’, but the findings of this study suggest that they should proceed with caution and not be tempted to implement an initiative without the necessary preparatory groundwork and/or adaptation.,

Funding

Funding is of paramount importance, as without adequate funding, initiatives are unlikely to succeed and of course may have to cease altogether. Some of the initiatives were funded for a time limited period – as local or national pilots – and respondents were striving to secure longer term funding from local sources (e.g. PCT, DAAT etc), whilst others had made that transition. In the context of public spending cuts being able to make a strong ‘business case’ is essential, for example, by reducing costly hospital admissions, ambulance call outs, A&E attendances. The hostel nurse project in Brighton was able to demonstrate considerable cost savings¹⁷ and joint funding was obtained from the local PCT and local authority for a further year.

The majority of initiatives had (or were being) evaluated. From the available information, it appears that evaluations are often internal and sometimes conducted post-hoc, however, evaluation was viewed as an important tool in demonstrating the success (or not) of an

¹⁷ The initial 16 week project cost £10, 000 and the cost savings (conservative estimate) were around £100,000 (source: presentation given at South East Alcohol Innovation closing showcase event, 11th May 2011).

initiative. Although a positive evaluation may not be sufficient in itself to secure further funding, it was regarded as essential.

Emerging areas of work

Within this study we found examples of innovative work across a broad spectrum of settings, target groups etc, however, there appears to be several specific areas of work where promising work is been undertaken:

- The entrenched dependent drinker
- Alcohol interventions within the criminal justice system
- Widening access to IBA

The entrenched dependent drinker

A number of encouraging, innovative approaches to working with the 'hard end' dependent drinkers have been highlighted in this study (see Box 25). These clients have complex medical and social needs and although high users of multiple services (health, housing, social services etc) and well known to local services providers they are often not well engaged and tend to 'rattle around' the system.

This group are generally low users of primary care services but often have very high attendance rates at A&E departments, and frequent hospital admissions – hence the term frequent flyer. Thus, when the spotlight was put on reducing alcohol related hospital admissions attention turned to ways of reducing admissions amongst this group.

Whilst there a number of differences between the different projects (e.g. location, organisation) they all involve:

- Intensive work with the client, sometimes daily contact;
- Flexibility on the part of the project worker (and their managers) as much of their work goes beyond the usual job description e.g. accompanying clients to appointments, sorting out benefits etc;
- Recognition that changing their alcohol use may not be a priority for this client group
- A 'holistic' approach i.e. need to sort out housing, debts, health, offending, alcohol treatment
- Small case loads (up to 10 people)

The early results of these projects are encouraging on number of fronts, for example,

- Reduced attendance at A&E
- Reduced hospital admissions
- Reduced ambulance call out
- Increased engagement with treatment services (including completing detoxification) and also with primary care
- Improved co-ordination between hospital and community services

What has also been learnt from these early projects is that such intense work can take its toll on workers. It is vital to have robust support systems in place to prevent 'burn out'. In addition, there needs to be planned transition from intensive support to mainstream services.

Box 25: Examples of projects

- Birmingham Total Place Pilot: Repeat Attendees at A&E and Acute Units
- Brighton Hostel Nurse
- Portsmouth Frequent Flyers
- Hasting Frequent Flyers
- Palliative care alcohol service, Aberdeenshire
- Self-help group in hostel (Bucks and Portsmouth)

Interventions with offenders across the criminal justice system

A number of projects that address alcohol use amongst offenders at various points of the criminal justice system, were identified, including: arrest referral schemes, treatment requirements, interventions in prisons and also initiatives that provide treatment and support on release. These initiatives reflect national policy (health and criminal justice), but are often adapted to local context and involve partnerships between health and criminal justice agencies in both delivery and funding. Respondents pointed to lessons learnt from similar initiatives aimed at drug users and also drew on the experience of the Home Office alcohol arrest referral pilots for adults and young people. The Home Office (2009) produced a guide to setting up alcohol arrest referral schemes with drew on the experience of the pilot sites¹⁸ and set out details of schemes. The final results of the evaluation Home Office alcohol arrest referral pilots are awaited.

Examples of alcohol interventions within the criminal justice system:

- Alcohol Arrest referral schemes: trained workers deliver IBA in custody suites to adults who have been arrested for alcohol offences.
- Young People's Arrest Referral Schemes (YPAR): IBA for young people aged between 10 and 18 years who were identified as being at risk of offending, or had been arrested for drug and/or alcohol related offences.
- Alcohol Treatment Requirements: treatment as alternative to a custodial sentence, clients are required to attend a structured programme.

¹⁸ First pilots began October 2007 (Cheshire, Ealing, Liverpool, Manchester) and then a second group in November 2008 (Bristol, Cleveland, Cumbria, North East Lincolnshire, Islington, Leicester, Northampton, Stoke, Swindon) and young people (Liverpool, Newcastle, East Sussex, Blackpool, Stoke-on-Trent/Staffordshire, Lincolnshire) began April 2009.

- IBA and treatment in prisons, for example, HMP Durham prison project, Offender Health Trainers in three prisons in East of England (HMP Weyland, HMP Chelmsford, HMP Norwich).
- IBA in probation, for example, Offender Health Trainers in Hampshire probation (Portsmouth and Southampton)
- Post- custodial treatment and support programmes,

Widening access to IBA

Brief Interventions (which later became known as IBA) emerged in the 1980s as a strategy to provide early intervention, before or shortly after the onset of alcohol related problems, with aim of reducing drinking rather than promoting abstinence (Babor *et al*, 2007). Whilst primary care has been the focus for the delivery of IBA, what is clear from this scoping study is that local areas have been seeking to widen out the delivery of IBA on several fronts:

- the settings that it is delivered in e.g. pharmacy, A&E departments
- who delivers the IBA e.g. workers in sexual health clinics, pharmacists, carers of older people

In addition, it is apparent that local areas are targeting particular groups of people thought to be at risk of drinking at hazardous or harmful levels e.g. young people, individuals with alcohol specific conditions. For a fuller examination and examples please see the case study in Chapter 6.

5: Alternative models for developing promising approaches-partnerships

Partnership working: an overview

Working in collaboration through formalised and structured partnerships has become an accepted and established way of working to address local needs and deliver strategically co-ordinated action. Despite considerable well-documented literature that sets out the principles and guidelines for partnership work, how partnerships actually work at local level has received little attention. Thom, Herring, Bayley, Waller and Berridge (2011) recently provided an overview of partnership working in England, inviting key informants and alcohol co-ordinators / leads, and using case study accounts, to explore this style of working, its strengths and weaknesses, and barriers to collaborative performance. This section draws on their report and provides an outline of partnership working as a framework for facilitating promising approaches.

Over the last few years, changes in alcohol partnerships have become more pronounced: they have increased in size and complexity; they are now more structured and formalised, linking into other partnership domains and organisational structures (Thom *et al*, 2011). A significant shift to targeting health related problems is similarly evident, which is nowadays often part of broader community safety agendas. While government guidelines strongly advocate partnership working, for example, identifying partnerships as an enabling mechanism for developing and implementing High Impact Changes (HICs), local level priorities are often found to conflict with more top-down structural restrictions and ingrained work cultures. The main challenges to partnership working identified by Thom *et al* (2011) are summarised in Box 26 below:

Box 26: Main challenges to partnership working

- Limited funding and resources – lack of and poor timing
- Lack of high level buy-in
- Failure to sustain long-term commitment – continuing involvement of the right people at the right level
- Agreeing shared priorities and goals – clarity needed in responsibilities/roles
- Managing size and complexity – non-coterminous boundaries and mixed urban/rural areas present particular challenges
- Institutional embedding – particular work/institutional cultures affecting emphasis on alcohol
- Dealing with professional cultures / silo working – linked to tensions between governmental department boundaries and regional / level needs
- Poor communication / information sharing – top-down and across partnerships

Despite these barriers, findings were largely positive regarding the structure and composition of partnerships (Thom *et al*, 2011) and a number of factors were elicited to enhance partnership working and develop more effective practices. These are outlined in Box 27 below and involve creating awareness of and addressing specific barriers, maximising identifiable strengths and providing mechanisms to facilitate effective practice.

Box 27: Key approaches to enhancing partnership working

- Build on a tradition of positive past experiences of partnership working
- Be flexible – frequently review policies/structures relating to national and local contexts
- Secure top-level buy-in and appoint champions
- Define clear roles and responsibilities of partners – set priorities and common goals and monitor and evaluate
- Build trust - can overcome ‘silo’ working and poor communication
- Break down professional silo working - through training, managing power imbalances between different work groups, build up long term relationships
- Ensure good communication – within, across networks and other agencies, and government departments
- Demonstrate gains – added value to members needs to be transparent

The authors suggest that the main aim of a partnership needs to be identifiable and the partnership examined for the unique contributions it makes to addressing alcohol problems. A strong recommendation emerging from the alcohol partnership research focuses on the need to continuously monitor the assumptions and hypotheses that underpin partnership approaches and to highlight the real world experiences of implementing and sustaining them.

In trying to identify initiatives that show ‘promise’, or that have been successfully delivered, partnerships emerge as an essential framework for:

- developing the design of interventions;
- effectively delivering them;
- sustaining changes within local structures through institutionalising effective practices .

The following case study, identified as a HubCAPP project, was instigated by an alcohol industry trade organisation and involved novel information-sharing features that became a hallmark of the project’s success. The example maps out the journey of the project from initial development via consultation with stakeholders and community members; through testing its effectiveness and working practices via pilot work; adapting and implementing the project in three diverse areas; and finally rolling it out widely across England and Scotland and Northern Ireland.

Case Study: Community Alcohol Partnerships

The Community Alcohol Partnership (CAP) provides a well documented and well evidenced example of a partnership approach whose focus is on reducing underage drinking. Extensive online resources are available including project background and evaluation reports for the initial areas in which CAP has been adapted and implemented. A toolkit has been developed of how CAP can be applied to a new area and a CAP officer is at hand to provide tailored advice and information. It is therefore a useful case study of how a partnership approach can be adapted and developed to meet differing local needs.

Background

The Retail of Alcohol Standards Group (RASG) is a group of retailers working to reduce underage alcohol sales since 2005. It originated from within the trade as a result of concerns around underage alcohol sales with an action plan aimed at:

- Reducing opportunities for underage buying of alcohol;
- Building effective partnerships between retailers and enforcement agencies;
- Developing intelligence-led enforcement techniques;
- Better understanding reasons for underage sales and developing preventative measures

(<http://www.wsta.co.uk/retail-of-alcohol-standards-group.html> Accessed 10.6.2011)

In 2007, when test purchasing results were found to be improving yet local underage drinking remained unaffected, RASG joined forces with Cambridgeshire County Council to develop and pilot the first Community Alcohol Partnership (CAP) to test out a novel approach. St Neots, a small market town with anti-social behaviour and youth-related disorder problems, was chosen for the pilot.

Aims

The overall aim of the project was to seek to eliminate underage sales. Three more specific objectives were identified:

- To reduce harm to society and victims (including young drinkers) through better enforcement of the existing legislative toolkit
- To deliver cultural change through better education
- To challenge and change public perceptions

Target Groups

Underage drinkers aged 12-18 years were the primary target group. Proxy purchasers/suppliers for underage drinkers, retailers selling to underage drinkers formed secondary targets. The whole community in terms of changing social norms around underage drinking was also targeted.

Key activities

A strength of the CAP approach guiding the choice of interventions is that tackling underage sales is recognised to be as much a socio-cultural problem as it is alcohol-related; one that involves designing specific targeted activities around alcohol sales together with changing cultural perceptions and attitudes in communities. As such, it has some of the features of a classical multi-component programme (MCP), in that an overall aim is identified and a set of initiatives, each with their own specific aims and objectives, are designed to mutually reinforce each other to address the overarching aim. Changing social norms is similarly a target shared by both models.

The CAP approach in the pilot used a combination of enforcement, education and community participation to tackle the demand and supply side of underage drinking but it diverges from the MCP approach in two ways: the make-up of its partners and a key process underpinning activities. Partners include enforcement agencies such as police and trading standards officers and, most distinctively, off-trade licensing such as local independent shops and larger national retailers. Information sharing is equally a process characteristic of the CAP approach involving retailers and local authorities committing to gather and share information about underage sales. For example, local authority trading standards can communicate with staff at head office of the RASG members which helps to address and resolve problems in local stores. Among the partnership's main objectives was to change perceptions among enforcement agencies and the general public that retailers should be perceived as victims rather than as supporting underage drinking. A summary of the various activities used to address project aims are shown in Box 28.

Box 28: Activities employed in CAP (St Neots)

- Information sharing - Retailers provided with Trading Standards / police staff telephone numbers to report attempted under-age / proxy purchasing.
- Enforcement - Regular patrols of hot spot areas (involving police, trading standards and licensing authorities), with police confiscating alcohol from under 18s.
- Education / enforcement - Trading Standards worked with store managers advising alleged offenders (young people or proxy purchasers) of reason for purchase refusal
- Education
 - Trading Standards and neighbourhood policing teams visited schools / local colleges to talk to students about legal / criminal issues relating to alcohol.
 - 'Drinksense' facilitated an alcohol awareness workshop for parents.
 - Letters and leaflets distributed to explain the law in this area and the implications of breaking it.
- Media advocacy - Local press reported regular news stories on the project.

Outcomes

Box 29: Key achievements from the pilot (St Neots):

- 42% decrease in anti-social behaviour from pre to post intervention; 94% decrease in under-age people possessing alcohol; 92% decrease in litter in hotspots
- Alcohol amounts found significantly lower than expected compared with similar areas
- Enforcement activities remained cost-neutral
- Better relationships between retailers and enforcers
- Change in perceptions of public spaces as being more pleasant
- No new problem hotspots

Box 29 above illustrates the impacts achieved by the pilot over a period of seven months. The pilot's success was largely attributable to the buy-in of different partners working in close collaboration to tackle a particular alcohol related problem and various contextual issues. It was felt to be a new way of working that did not increase workloads but redeployed existing enforcement tools with no extra financial burden, as summarised in the following comment:

'It is simply a new way of working, firstly in joint patrols and activities with Trading Standards, secondly bringing retailers on board rather than making them the enemy. It is about intelligence gathering as much as enforcement, and is revenue neutral. It does not cost any extra money; it is just a smarter way of working, rather than increasing work.....We will continue to run patrols as it's what the community has asked for.'

(Mark Woolner, St Neots and District Police Inspector,

(http://www.cambridgeshire.gov.uk/NR/rdonlyres/3EEB9A78-DAE0-4393-AF34-9CCC7D9983B7/0/Community_Alcohol_Partnership.pdf Accessed 10.6.2011)

Transferability

RASG and Cambridgeshire Trading Standards have since developed a toolkit which can be applied elsewhere. They are keen to stress the variation likely to be found in demographic profiles and social problems in other areas and to offer advice regarding lessons learned and sharing of experiences. As a model of good practice CAP was subsequently adapted and implemented in a pilot project in three areas in Kent during 2009 and independently evaluated by the University of Kent's Evaluation Team.

(<http://www.tradingstandards.gov.uk/kent/documents/Main%20Report%20KCAP2.pdf> Accessed 10.6.2011)

Box 30: Key achievements in Kent areas (KCAP)

- Criminal damage reduced by 28% overall, 6% more than in non intervention areas
- Positive results obtained from public surveys on six measures compared with three in non intervention areas:

teenagers hanging around; people drunk and rowdy in public; vandalism and graffiti; rubbish and litter; drugs; anti-social behaviour
- Increase in people feeling safe in their area (twice the change in non intervention areas); feeling safe walking alone in the day (1% increase); walking alone at night (twice the change in non intervention areas)

Encouraged by the findings of the evaluation report outlined in Box 30, CAP projects have been rolled out in Kent by the County Council and taken up in other areas of England and Scotland with plans also for Northern Ireland; there are currently some 20 CAP schemes in operation or being planned. (<http://www.wsta.co.uk/images/stories/capnews2010.pdf> Accessed 10.6.2011)

While areas will have different priorities to address and different socio-cultural backdrops, there are useful lessons to be learned from KCAP in setting up similar new projects. These have been adapted from the findings of the University of Kent Evaluation report on the KCAP projects (Oldfield and Hale, 2009) and are summarised in Box 31 overleaf.

In setting up a new CAP project, the importance of preparatory work is stressed together with the commitment of key partners and implementing an appropriate management structure for delivering interventions. Partners would generally comprise the following: local authorities, police and trading standards, retailer members of RASG, children and young people's services, local health and youth working groups, safer community teams, Drug and Alcohol Action Teams (DAATs), Schools and independent retailers and shops. (<http://www.wsta.co.uk/images/stories/capleafletweb.pdf> Accessed 10.6.2011). Functioning in a co-ordinating and advisory role, RASG has more recently funded a CAP officer to help develop, launch and manage CAP projects, part of the officer's work remit being to resolve problems with retailers, offer support through toolkits, signage, organise events and manage local media. (<http://www.wsta.co.uk/images/stories/capleafletweb.pdf> Accessed 10.6.2011)

Box 31: Lessons learned from Kent Community Alcohol Partnership projects

- Strong partnerships working co-operatively is essential
- Consult extensively with local agencies to determine scale and nature of local problems – KCAP findings emphasise the complexity of tackling alcohol-related issues associated with crime and anti-social behaviour
- Organisation enhanced by designated local project officer e.g. from trading standards
- Local dialogue should feed into area level dialogue and so become part of the learning experience for all agencies
- Adopt a problem-solving approach to project management and problem solving; encourage a can-do attitude; recognise challenges in this approach as growth in partnership numbers accelerates
- Ideally, design a standardised set of outcome measures focussing on specific targets to monitor progress towards achieving targets
- Efficient communication and intelligence-sharing is key; support can be provided when needed and problems can be rapidly assessed and addressed
- Embed effective practice into structures to institutionalise change e.g. Accredited Retailer and Publican document now incorporates some KCAP key activities
- Design interventions to tackle wider socio-cultural impact of drinking at development stage – recognise that changing social norms takes a long time
- Enlist partners with expertise and responsibilities involving particular target groups e.g. Education, Health and Youth work in the KCAP project with expertise in working with young people
- Encourage the alcohol industry to contribute to the implementation of CAP activities
- Recognise that funding may need to be secured for work that falls outside an agency's work remit

Amongst its recommendations from the three projects piloted in Kent, the University of Kent's Evaluation report (ibid) suggests securing the involvement of agencies with expertise in relevant areas, so that agencies with expertise and responsibilities in other fields can then focus on their own allocated activities. An example of this mentioned in the report is the delivery of educational aspects of KCAP which could be done by Education, Youth Work, Health and the alcohol industry, leaving Police and Trading Standards agencies to focus on their own services. The report goes on to suggest that an extensive partnership group is likely to be needed so that roles and responsibilities can be allocated accordingly.

Creating community awareness is an important aspect of CAP but the KCAP project found variation in levels of involvement from community groups in the three Kent pilot projects, recognising that there are limitations to what can be achieved. In one particular area, Edenbridge, the relatively small size of the area was believed to contribute to the highly successful impacts achieved, and discussions at local level revealed a strong sense of

community in which people, such as the police and young people, knew each other, thereby enhancing awareness of the project and, most likely, its effects. The following outcomes are summarised in a final draft of the Alcohol Improvement Program in the East of England report (Stevens, 2011)

http://www.alcohollearningcentre.org.uk/library/Resources/Alcohol_Legacy_Document_2009_2011_FINAL_09_11.pdf) accessed 3rd November 2011:

- The CAP approach may be particularly effective in small well defined communities where the main problem is clearly identified as underage drinking.
- The extent to which proxy purchasing (particularly parental supply of alcohol) is addressed may warrant further development
- Linking CAP approaches with broader issues associated with underage drinking (e.g. young people's health and welfare services) may also be beneficial to a wide range of local agencies.

Sustainability

Ensuring the sustainability of successful projects requires that changes in norms, behaviours and social structures become embedded in local policies and practice (Thom and Bayley, 2007). The key KCAP activities have been embedded into the Accredited Retailer and Publican Agreement document which offers accredited membership to retailers and publicans and in effect provides a means by which the alcohol trade can demonstrate support for the principals of KCAP (Oldfield and Hale, 2009).

A further indicator noted by Thom and Bayley (2007) is that alcohol programmes that are collaborative and that can become established within wider agendas such as community safety may increase longer term effects. In this respect it is significant that the CAP approach has been endorsed by the Home Office and Department of Health and CAP projects are currently being mainstreamed throughout England and Scotland with further plans for Northern Ireland. The indications are that sustaining the impacts of the project can be achieved as long as the key partnership structures are maintained and this is more likely given government endorsement of such projects. That the enforcement and education strands are cost neutral adds to project viability and potential longer term successes.

Summary

- Working in novel partnerships that include police, retailers and trading standards enhances the success of approaches designed to tackle underage drinking and associated anti-social behaviours
- Locating the alcohol related problem, underage drinking, within its socio-cultural context has allowed a reframing of how retailers are perceived – more as victims, less as perpetrators of underage selling
- Targeted enforcement and focused education can be delivered by reallocating existing resources which are cost-neutral. This enhances the possibility of sustaining project impacts and longer term cultural change.

The CAP approach may be at its most effective in small well defined communities where underage drinking is clearly identified as the main problem.

6. Alternative models for developing promising approaches - innovation in health and social care

Innovation in health and social care: an overview

Although the roots of the innovation approach are firmly within the business sector, it has become increasingly influential within the public sector and third sector as a means to tackle a range of social challenges, including those faced by society because of our aging population, chronic health conditions such as diabetes and climate change (European Union/Young Foundation, 2010). The NHS has identified innovation as a key mechanism to improve the quality of care provided (DH/NHS, 2010). The Quality, Innovation, Productivity and Prevention (QIPP) programme is a large scale transformational programme for NHS, involving NHS staff, clinicians, patients and the voluntary sector which aims to improve the quality of care delivered by the NHS whilst at the same time making efficiency savings, with any savings being reinvested in frontline care (DH/NHS, 2010). Within this study we found the innovation model being used to test new approaches to reducing alcohol related harm in the South East Alcohol Innovation Programme (SEAIP). Before considering the specifics of the SEAIP, the innovation approach will be briefly outlined.

Disentangling the terminology

The terms social enterprise, social innovation and social entrepreneurship are often used synonymously, however, in a report to Bureau of European Policy Advisors, Social Innovation eXchange (SIX) and the Young Foundation argued that whilst there are overlaps there are also important distinctions (European Union/Young Foundation, 2010, p15.). In brief:

Social enterprises are businesses with primarily social or environmental objectives and their profits are reinvested for that purpose in the business or community rather than mainly being paid to shareholders or owners. Social enterprises are distinctive from traditional charities or voluntary organisations in that they generate the majority, if not all, of their income through the trading of goods or services rather than through donations.

Social enterprises vary greatly in scale, from small community-owned village shops to large organisations delivering public services. Examples of social enterprises include The Big Issue, Jamie Oliver's 15 restaurant, Divine Chocolate and Surrey Health Care (see Social Enterprise Coalition website). According to the Annual Survey of Small Businesses UK 2005-2008 there were approximately 60, 000 social enterprises in the UK, which is about 5% of businesses with employees (Department for Business Innovation and Skills, 2010) and in 2009 a survey indicated that social enterprises were continuing to thrive even within the context of a recession (Social Enterprise Coalition, 2009).

The Department of Health set up a Social Enterprise Unit in 2005 to support social enterprises to deliver health and social care, followed by establishment in 2007 of the Social Enterprise Investment Fund (SEIF) in order to stimulate social enterprise in the health and social care field by investing in new and existing enterprises. Examples of social enterprise in the health and social care field include, Wakefield Integrated Substance Misuse Services, Leicester Homeless Healthcare service. Using data collected by State of Social Enterprise Survey it has been estimated that there are more than 6,000 social enterprises delivering health and social care within the NHS (Social Enterprise Coalition, 2009). (For more details of the Department of Health programme, please visit the webpage <http://www.dh.gov.uk/en/Managingyourorganisation/Socialenterprise/index.htm>).

Social entrepreneurship is a term used to describe “the behaviours and attitudes of individuals involved in creating new ventures for social purposes, including the willingness to take risks and find creative ways to using underused assets” (European Union/Young Foundation, 2010, p.15). Gregory Dees described them as “one species in the genus ‘entrepreneur’ (2001, p.2) as they are entrepreneurs with an explicit social mission which is central to all they do”.

Social innovation is broader than social enterprise or social entrepreneurship. Social innovations and has been defined as: “new ideas (products, services, models) that simultaneously meet social needs (more effectively than alternatives) *and* create new social relationships or collaborations, in other words they are innovations that are both good for society *and* enhance society’s capacity to act” (European Union/Young Foundation, 2010, p.17, original emphasis).

So what is innovation?

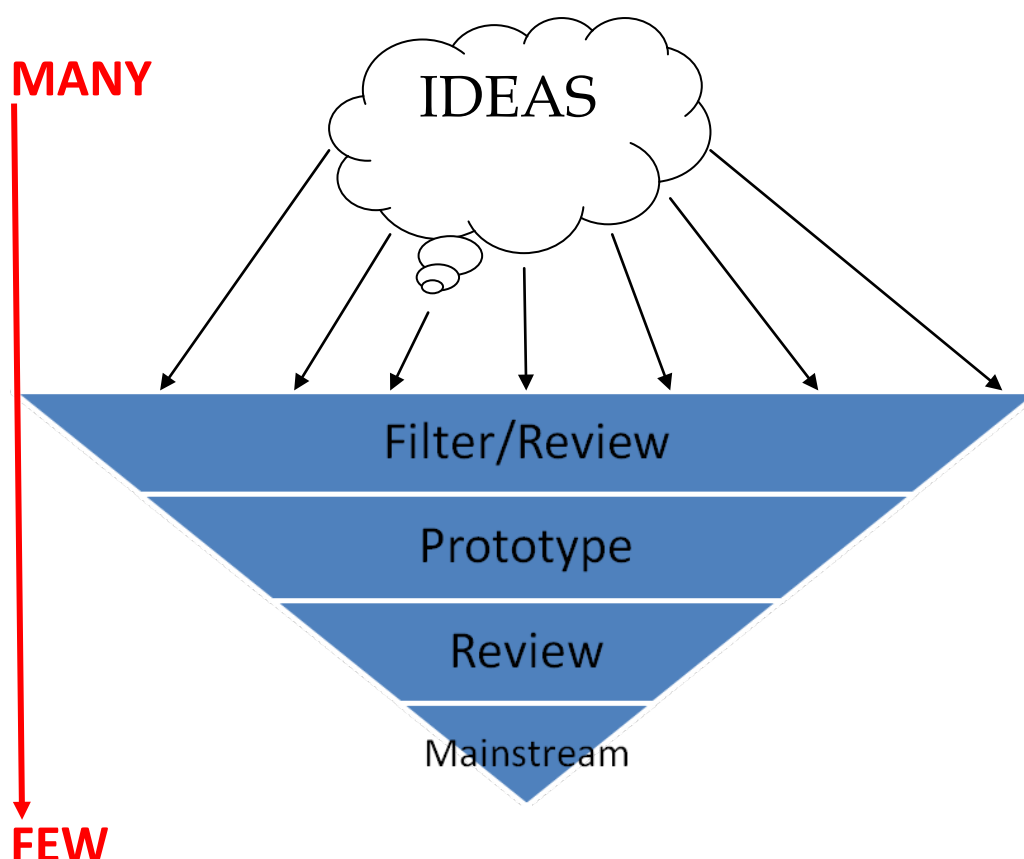
Whilst there are number of definitions of innovation, key to them all is the concept of *change that improves performance* either because it outperforms previous practice or creates a new dimension of performance. Philis *et al* (2008) argue that to be considered an innovation a process or outcome must meet two criteria, namely novelty and improvement. First, although innovation need not necessarily be original, it must be new to the user, context or application. For example, the use of call centres whilst commonplace in business (e.g. banks, airlines etc) was an innovation when applied in 1998 to the NHS in the form of NHS Direct. Second, to be considered an innovation, an outcome must either be more effective or more efficient than the existing alternatives i.e. it must be an improvement. In addition, Philis *et al* (2008) argue that innovation should be more sustainable or just, for them sustainable solutions are ones that are both environmentally and organisationally sustainable. For Mark Napier of the Centre for Public Innovation (CPI) another key element is the application of the new idea; without testing it will remain just a ‘good idea’. For him innovations entails:

1. new ideas (or new application of an idea);
2. new way of thinking about a problem;
3. application of the new idea;
4. improvement over previous practice (Napier, 2011)

Putting innovation into practice: the innovation model

Innovation is both a process and a product/outcome (Philis, 2008). In simple terms the innovation model involves a series of steps (see Figure 3) which act to filter and refine the ideas to produce an innovation(s). The first step is to collect lots of ideas (e.g. ways to improve a service) casting the net widely to get ideas from a broad range of people. Ideas are the 'raw material' of innovation and so it is crucial to have a working environment that encourages creativity (Goffin and Mitchell, 2005). The criteria that will be used to assess the ideas should be clearly stated. The next step is to review the ideas and filter out those which do not meet the 'brief' (i.e. looks like usual practice). A 'balanced scorecard' approach is often used to select ideas; this involves 'scoring' the ideas on the basis of the set criteria and using a 'cut off' score to select ideas. The selected ideas are then put to the 'test' and assessed, again using a common set of criteria and the least successful ideas are discarded (see Davila *et al*, 2006, for further details on measurement). How 'performance' is measured will depend on the problem being addressed by the innovation, but in relation to health and social care innovations key domains include effectiveness, efficiency, equity and safety. This test and review process can be repeated (multiply if required) in order to refine the ideas and ultimately to be left with one (possibly more) innovation(s) that have been clearly shown to change or outperform previous practice.

Figure 3: Innovation model



Source: adapted from presentation given by Mark Napier given at SE Alcohol Improvement Showcase event May 2011.

The South East Alcohol Innovation Programme

The SEAIP was commissioned by the Department of Health as part of the Alcohol Improvement Programme (AIP) and delivered by a well established social enterprise company, The Centre for Public Innovation. The SEAIP was initiated by the Regional Alcohol Manager (RAM) for the South East of England in order to deliver the key outcome of the AIP which was to reduce alcohol related hospital admissions. The programme, which ran from October 2009 to March 2011, set out to encourage frontline staff to formulate innovative projects based around the High Impact Changes bid for small grants to pilot these innovations and evaluate their impact on reducing alcohol related admissions.

Getting the innovation message to the South East

The Centre for Public Innovation used three mechanisms to communicate with stakeholders in the South East about the programme:

- Website <http://www.southeastalcohol.org.uk/>
- Email: initial email to explain bi-monthly email newsletter
- Training events

A broad range of people and organisations with an interest in alcohol (e.g. alcohol commissioners, public health leads, community safety partnerships, third sector organisations, fire and rescue services etc) were contacted by email to explain the programme and invited to a free training event¹⁹ about innovation. In addition, to learning about what innovation is they were encouraged to generate ideas (based around the HICs) about different approaches to tackling alcohol related harm and reducing alcohol related admissions. The aim was to show people 'how to' innovate and for them to go back to their 'day job' and to come up with new ideas that could be piloted. The website contained all the information provided at the workshop for those who could not attend.

Supporting Innovation

The SEAIP has awarded small grants to allow innovative ideas to be 'tried out'. All stakeholders across the SE were eligible to bid to receive grants. In Year One (2009/2010) the first round of bids were for seasonal campaigns, and areas which already had seasonal campaigns for December 2009 could apply to extend the works. The bids had to demonstrate the 'additionality' the funding would bring. The second round of grants asked for stakeholders ideas based around the HICs and 25 of the 65 bids received were funded (Napier, 2011). The bids were assessed on the basis of six criteria:

- 1) Target group: clearly defined target group/client group
- 2) Alcohol use: clearly defined alcohol behaviour (e.g. harmful drinking)
- 3) Geographical area: clearly defined geographical location/focus
- 4) Outcome: clearly defined client outcome(s)
- 5) Performance: clearly defined performance target(s)
- 6) Budget: clearly defined budget with individual line items.

The 'scores' for each criteria were added together to give a total assessment score. In addition, four weighting factors were taken into account:

- 1) High focus areas, that is areas in the top quintile for alcohol related hospital admissions
- 2) Attendance at training day by a member of the bidding team/organisation
- 3) Coverage of more than one HIC
- 4) Impact assessment i.e. likelihood of success.

The projects were funded for 3-6 months and had to be able to demonstrate their 'value' within that timeframe. In the first year over £145,000 was invested in grants to innovative projects. (<http://www.southeastalcohol.org.uk/events.php?id=17>) An 'Innovation Showcase' event was held in July 2010 to 'showcase' the innovation projects to the region, share learning from the projects and encourage others to implement ideas from the projects in their areas.

¹⁹Three whole day training events were held and approximately 90 people attend in total.

Next steps: identifying 'promising' projects

All the projects funded were asked to complete a self-evaluation form²⁰. A balanced scorecard with six variables was used to assess the 'success' of the projects:

1. Alcohol related admissions
2. Outcomes
3. Budget
4. Sustainability
5. Diffusion
6. Performance

Each variable was given a score:

0 for negative impact, e.g. higher level of hospital admissions than mainstream approach, poorer outcomes etc

5 for neutral, e.g. met targets, stayed within budget etc

10 for some additional performance, e.g. some extra funding leveraged, likely to be replicated elsewhere

15 for high performing, e.g. significant chance of being commissioned, significant client impact etc

On the basis of these scores five 'high impact' innovations projects were identified:

1. Frequent Flyers (individuals with high levels of repeat alcohol related admissions)
2. Pharmacy IBA
3. Hostel Clinical Nurse
4. Supported housing self-help group
5. Hospital Health Care Workers delivering IBA

(see Box 32 for brief descriptions, full descriptions are available at

<http://www.southeastalcohol.org.uk/>). Both the 'Frequent Flyer' and Hostel Clinical Nurse involved intensive, focused work with a small group of drinkers with complex, entrenched problems, high levels of contact with multiple services and repeated hospital admissions for alcohol-related conditions. Alcohol workshops were used as a vehicle to raise awareness and facilitate the formation of a self-help group amongst residents of supported housing who were reluctant to engage with specialist services. The Pharmacy IBA and Hospital Health Care Workers delivering IBA took IBA out of the primary care setting and involved new groups of staff to deliver IBA.

²⁰There were no funds available to conduct external evaluations of the projects.

Box 32: High Impact Innovations– Successful projects

Portsmouth Frequent Flyer: Portsmouth has the highest level of alcohol related hospital admissions in the South East, with a small number of patients being re-admitted to hospital very frequently and thus contributing significantly to this statistic. The project provided a specialist community based nurse to work intensively with the 10 patients with the highest level of alcohol related repeat hospital admissions, to coordinate their care, reduce the impact on other services and ultimately reduce the likelihood of further admissions. The project is described in more detail in Chapter 7.

IBA Delivered by Hospital Healthcare Workers: Healthcare support workers in Accident & Emergency, Medical Assessment Unit and Gastro-enterology wards come into contact with all patients admitted and usually have more time available to deal with those patients than nursing and medical staff. Training these workers to screen patients to identify problematic alcohol use and deliver brief advice to those patients whilst performing basic care tasks enables them to deliver information at a point of crisis for individuals, to impact on their alcohol use and reduce repeat admissions for alcohol related conditions.

Brighton and Hove Clinical Nurse Project: The project funded a clinician to provide clinical support, and training, for hostel staff to support previous rough sleepers with alcohol dependency to reduce their drinking and address attendant health problems, within a 24 hour supported environment. The project specifically targeted this group for whom inpatient detoxification does not work – usually ending with a return to the hostel environment and resumed drinking. The project aimed to replace this cycle with personalised, gradual detox within the hostel environment.

Hampshire Pharmacy IBA: The project engaged with community pharmacies to provide proactive alcohol brief advice offering health awareness, understanding units, early identification of possible excess, brief advice, data capture on awareness and units. For more information see the Case Study: IBA later in this Chapter.

Supported Housing Self-Help Group: The project raised awareness of alcohol use amongst clients and established a client help group within a supported housing setting. The project commenced with the delivery of alcohol awareness workshops to the client group to raise awareness of alcohol related harms. Workshops were delivered within the supported housing setting and used as a basis to establish the self-help group.

Source: <http://www.southeastalcohol.org.uk/> (accessed 20th May 2011)

Round Two grants: putting the ‘promising’ projects to the ‘test’

A key aim of the SE Alcohol Improvement was to identify new approaches that could be ‘industrialised’ i.e. to become mainstreamed across the country. Thus, the next step was to see whether these High Impact Innovations could be successfully transferred to another area. Services specifications were written for each of the five ‘High Impact Innovations’ and the SE stakeholders were invited to bid for grants to roll out one (or more) of these projects in their area. Bidders were instructed to refine the specifications to best meet local needs and context. Twenty three bids were received in September 2010 and 11 were supported including:

- Brighton and Hove Frequent Flyers - Brighton and Hove DAAT- £15,000.00
- Frequent Flyers at St Richards Hospital, Chichester, West Sussex - West Sussex PCT- £15,000.00
- Hastings frequent flyers - Medway Council - £12,750.00
- Peer Recovery Facilitators - Portsmouth Council- £8,250.00
- Self-Help Alcohol Awareness Groups in Supported Housing settings - Surrey PCT - £7,000.00 (<http://www.southeastalcohol.org.uk/news.php?news=26>)

The total funding for the 11 pilot projects was £143,000. By February 2011 there were indications that some of these pilots were being incorporated into mainstream provision. From the website:

- “The Brighton Frequent Flyers project has received further funding to allow it to continue running up until November 2011.
- The Brighton Clinical Nurse project has received funding from both the City Council and PCT to fund the post for a full year, with a view to possible further funding after that pending outcomes achieved.
- The Hastings Frequent Flyer model has helped to develop a strong working relationship between the Emergency Department team and colleagues in alcohol treatment. Clients beyond the scope of the pilot are being referred into treatment on an almost daily basis.” <http://www.southeastalcohol.org.uk/news.php?news=34> 25th February 2011 (accessed 15th March 2011).

A closing ‘Innovation Showcase’ was held in May 2011 in order to which provided an opportunity for learning from the specific projects and the SEAIP as whole to be shared. Early lessons, highlighted at the closing event, included:

- the recognition that the time frame set for projects to be up and running was too short which created avoidable problems;
- the need to pragmatic and flexible, learning and adapting projects in order to achieve the desired outcome (Napier, 2011).

The SEAIP was independently evaluated (CPI, 2011), the evaluation focused on the ten High Impact Innovation projects funded in Year 2 of the SEAIP (see Box 33 for key findings), concluding that the ten projects examined could be transferred and succeed anywhere in the country. The evaluation highlighted the importance of ‘buy-in’ across sectors and organisations, and also at the various levels of the organisation (from senior managers through to front-line staff), and the need to take into account the local context (location of services, alcohol needs assessment, local partnerships etc) when designing, delivering and transferring initiatives.

Box 33 South East Alcohol Innovation Programme: Key findings from the evaluation

The ten projects examined could be replicated and succeed elsewhere.

Five of the projects identified significant cost savings:

- Alcohol IBA Training for Pharmacists (Windsor)
- Brighton and Hove Frequent Flyers
- Brighton and Hove Hostels Clinical Nurse
- Frequent Flyers at St Richards Hospital, Chichester
- Hastings Frequent Flyers

Six of the projects reported reduced hospital admissions among their client groups:

- Brighton and Hove Frequent Flyers
- Brighton and Hove Hostels Clinical Nurse
- Frequent Flyers at St Richards Hospital, Chichester
- Hastings Frequent Flyers
- Peer Recovery Facilitators , Portsmouth
- Southampton Alcohol Intensive Case Management Project

Seven projects secured funding to continue, three of which that have been taken up as NHS Quality, Innovation, Productivity and Prevention (QIPP) initiatives, indicating their strong potential to demonstrate innovation and increase quality and productivity:

- Frequent Flyers at St Richards Hospital, Chichester
- Southampton Alcohol Intensive Case Management Project
- Alcohol IBA Training for Pharmacists (Windsor)

Commissioners of alcohol projects should consider using the innovation approach to identify local initiatives

Source: SEAIP (2011)

Summary:

- Innovation approach has its origins in business but is increasingly influential in the health and social care arenas
- Innovation is about taking new ideas (or new application of an idea) or a new way of thinking about a problem and applying the new ideas
- The SEAIP used as innovation approach and provided a vehicle for local areas to try out new ideas without 'risk' and then to 'test' them in other localities.
- The SEAIP harnessed the tacit knowledge of practitioners to address seemingly intractable problems and to devise ways that they could be tackled more effectively.
- The SEAIP has generated five 'promising' approaches, with the frequent flyers, Pharmacy IBA and hostel clinical nurse showing particular promise.

Case Study: 'The Portsmouth 'Frequent Flyers' Project'²¹

This case study has been chosen as it provides a clear example of a promising initiative produced by applying an innovation approach and the processes involved in institutionalising an initiative. In this example a novel approach to a longstanding 'problem' was piloted and then tested in other areas.

Background

The project began as a pilot project (Jan – April 2010), having being awarded a £15,000 'High Impact Change' grant from the South East Alcohol Innovation Programme.

Aims

The project set out to work with a small group of individuals with the highest level of alcohol related repeat admissions, to co-ordinate their care, reduce impact on other services and ultimately reduce the likelihood of further admissions.

Target group

The 'top 20' individuals with repeat alcohol related hospital admissions (20+ admissions in previous 12 months) were identified from Medical Assessment Unit (MAU) records. This group, whilst, well known to acute services had a history of poor or no engagement with community services and primary care.

²¹This section is based on a presentation made by Alan Knoebel, Alcohol Strategy Lead for Safer Portsmouth, at a workshop Identifying 'promising' approaches to reduce alcohol related harm, held 18th November 2010 in London and information available on the South East Alcohol Improvement website.

Key activities

The initial plan was for a specialist nurse to lead the project, but recruitment difficulties, meant that this was not possible and a worker without nursing qualifications was appointed as a community specialist worker. Five of the 'frequent flyers' were engaged by the community specialist worker who worked very intensively with this group, seeing them almost daily. The worker helped the individuals deal with a broad range of issues including housing, debt management, mental health, often accompanying individuals to 'routine' appointments.

Outcomes

Targets and outcomes for the pilot are shown in Box 34 below. For those who engaged with the community specialist worker, during the 3 month pilot period there was a reduction in admission rate of 85%, better engagement with community treatment and increased completion of detoxification. However, the intensity and nature of the work had a negative impact on the worker who felt unable to continue in post past the pilot stage. It became evident that the level of supervision and support the worker was receiving needed to reflect the intensity of the work they were engaged in.

Box 34: Target and outcomes

Output targets set by the original pilot

- Identify and assess the 20 most prolific patients at MAU over past 12 months
- Engage 20 of this cohort in specialist community support programme
- Demonstrate reduction in admissions

Outcomes set by original pilot

- Reduced rate of re-admission to hospital in the target group of patients
- Increase number of successful alcohol detoxifications for patients admitted via MAU
- Better coordination of treatment/care between hospital and community services

Outcomes

- Engaged only 5 of the 20FFs
- Average of 37 admissions in the previous 12 months
- Reduction in admission rate for those engaged of 85%
- Prevented 24 admissions in 3 month pilot
- Almost daily contact with each patient
- Better co-ordination between hospital and community services
- Increased completion of detoxification and engagement in community treatment in community treatment
- Estimated saving of £21,000 (including cost of worker).

Adaptations

The process of conducting the pilot highlighted a number of issues which needed to be addressed (see Box 35).

Box 35: Learning from the pilot

- Best to engage patient whilst they are an inpatient
- Need effective alcohol liaison nurse within the acute hospital
- Treatment on its own is not sufficient - this group have very complex health needs
- Need intensive back up support from the outreach team and treatment services
- Intensive supervision of worker required
- Alcohol treatment is only one of many issues that needs to be addressed
- Other key needs; housing, debt, benefits, mental health and primary care.
- Perseverance – not taking ‘no’ for an answer

The project was adapted and the pilot extended for another year (July 2010-July 2011). Key changes made in the light of the experience of the pilot were:

- New worker placed in a service with outreach and structured day programme
- Alcohol Nurse Service established within the hospital
- Running psychosocial groups in the hospital and community
- 60% reduction in admission rate – approximately 24 prevented

Transferability

All the pilot projects given ‘High Impact Change’ grants were evaluated and from a group of 25 pilot projects the ‘Frequent Flyers’ project was identified as one of five ‘High Impact Innovations’, a service specification was developed and stakeholders across the SE were invited to bid to replicate the ‘Frequent Flyers project’ using the service specification. Stakeholders were encouraged to ‘refine, improve or extend the models that had already been ‘tried and tested’. Another three ‘frequent flyer’ projects were funded on a pilot basis for three months— Brighton and Hove, Chichester and Hastings.

Sustainability

By February 2011, there were indications that the pilots were being incorporated into mainstream provision:

- “The Brighton Frequent Flyers project has received further funding to allow it to continue running up until November 2011.
- The Hastings Frequent Flyer model has helped to develop a strong working relationship between the Emergency Department team and colleagues in alcohol treatment. Clients beyond the scope of the pilot are being referred into treatment on an almost daily basis.” (<http://www.southeastalcohol.org.uk/news.php?news=34> 25th February 2011, accessed 15th March 2011).

Case Study: Identification and Brief Advice (IBA)

This case has been selected as it provides an example of the application of the innovation approach, but in this example the intervention- IBA – is well evidenced and thus not ‘new’ but what is novel and innovative is its application in new settings and by a broader range of professionals.

Brief Interventions (which later became known as IBA) emerged in the 1980s as a strategy to provide early intervention, before or shortly after the onset of alcohol related problems, with the aim of reducing drinking rather than promoting abstinence (Babor *et al*, 2007). There is extensive research evidence to show that significant reductions in drinking can be achieved in a variety of health care settings (Kaner *et al*, 2007). However, diffusion of IBA in routine health care has been slow (Nilsen *et al*, 2008). Whilst primary care settings have been the focus for delivering IBA, general practitioners have shown a continued and marked reluctance to incorporate IBA into routine practice (Nilsen *et al*, 2008). IBA was identified by the DH as a High Impact Change and PCTs have been encouraged to implement IBA, for example, through the use of a direct enhanced service (DES) for alcohol. Introduced in April 2008, an alcohol DES financially rewards GP practices for screening newly registered patients aged 16 and over using either the AUDIT-C or FAST²². It also aims to deliver a simple brief intervention to help reduce alcohol-related risk in adults drinking at hazardous and harmful levels using the AUDIT²³ (NHS Employers, 2008; DH, 2011). In addition, locally enhanced service (LES) for alcohol to meet local needs can also be provided and involve screening patients with specific alcohol-related conditions (DH, 2011), for example, adult

²²Alcohol Use Disorder Identification Test- Consumption (AUDIT-C) and Fast Alcohol Screening Test (FAST) are validated questionnaires (see Appendix 4 for further details).

²³ Alcohol Use Disorder Identification Test is a validated questionnaire developed by the WHO (see Appendix 4 for further details).

patients with hypertension (see Box 36 for an example from scoping study of promising and innovative approaches).

Box 36: Alcohol LES a pilot project

Primary care screening of adults using with:

- Hypertension or
- Cardiac arrhythmias or
- New diagnosis of depression

Those that screen positive were given:

- AUDIT 8-15: 5 minutes brief advice about alcohol
- AUDIT 16-19: 2 X 20 minutes brief interventions about alcohol
- AUDIT 20+: referred to specialist services, or if not motivated, given 2 X 20 minutes motivational interviewing about alcohol

Source: respondents in scoping study

What is evident from this scoping study is that local areas have been seeking to widen out the delivery of IBA on several fronts:

- the settings that it is delivered in e.g. pharmacy, A&E departments
- who delivers the IBA e.g. workers in sexual health clinics, pharmacists, carers of older people

In addition, it is apparent that local areas are targeting particular groups of people thought to be at risk of drinking at increasing or higher risk levels e.g. young people, individuals with alcohol specific conditions.

IBA in alternative settings to Primary Care

Pharmacy

The scoping exercise highlighted that community pharmacies have recently been identified as a potentially important setting for the delivery of IBA. HubCAPP includes information on community pharmacy IBA projects in:

- Leeds (a pilot feasibility study conducted in 2006)
- Hampshire
- Wirral

- Lambeth

In addition, we identified from the Alcohol Learning Centre the North West pharmacy pilot: 'Alcohol Screening & Brief Intervention Service in Community Pharmacies' across the North West of England. Pharmacy Brief Advice was one of the five 'High Impact Innovations' identified by the South East Innovation programme (funded Hampshire pharmacy projects).

Why pharmacies?

In 2008 a White Paper on Pharmacy, *Pharmacy in England: building on strengths - delivering the future*, recognised pharmacies and pharmacists as an accessible but under- utilised health care resource (Department of Health, 2008c). Many people seek health advice from pharmacists on a routine basis, with an estimated 1.2 million people seeking health advice every day (Department of Health, 2008c, p.14) Market research conducted on behalf of the DH found that with 84% of adults visit a pharmacy– 78% for health reasons, at least once a year, with three quarters of people having visited in the last six months (Department of Health, 2008c, p.14).

Pilot projects

Hampshire: Two pharmacy based pilot projects took place in Hampshire (May-July 2009) funded as part of the Hampshire Innovation Fund (see Box 37). One was situated in a general pharmacy setting and the other targeted those coming in for Emergency Health Care (i.e. the 'morning after' pill). Each project received £4000 which covered the costs of training and materials. Ten community pharmacies in Rushmoor and Hart were selected. Pharmacists and one key member of staff (Health Promotion lead) completed the online Alcohol Brief Interventions training via the Alcohol Learning Centre. The AUDIT-C, was used to assess alcohol-related harm. Brief advice was offered where clients scored five points or above. Where dependence was suspected, a referral was made to specialist treatment providers. This work was extended under the SEAIP and subsequently, Pharmacy IBA was identified as a High Impact Innovation and a pilot project was funded in Windsor, Berkshire.

Box 37: Hampshire pharmacy IBA pilot project

Aim:

- To use pharmacies to deliver brief interventions and;
- Support those drinking at a low and medium risk level.

Objectives:

A community pharmacy delivered, pro-active alcohol brief intervention service which offers:

- Health awareness of understanding units
- Early Identification of possible excesses
- Brief interventions advice
- Captured data on awareness and units consumed
- Signposting/referral for additional support were required

Outcomes for initial 3 month pilot (May -July 2009)

In 10 community pharmacies:

- Screening opportunistically and proactively
- 794 consultations
- 801 interventions

Of the 801 interventions:

- 464 people were offered education information
- 296 offered advice
- 41 were referred for specialist treatment

In 50 Emergency Health Care Pharmacies

- 214 consultations
- 249 interventions

Of the 249 interventions: 140 received educational information; 102 advice and 7 were referred.

Source: Alcohol Learning Centre,

<http://www.alcohollearningcentre.org.uk/LocalInitiatives/projects/projectDetail/?cid=6462>

Windsor: The pilot involved training community pharmacists to deliver IBA within community pharmacy settings. Pharmacists are paid to carry out medicine use reviews (MURs) with customers and the MUR was identified as a prime opportunity to deliver IBA. In addition, pharmacists were encouraged to deliver IBA opportunistically (e.g. to those requesting the morning after pill).

Although 22 pharmacists undertook training and they received an enhanced payment for delivering IBA, only six pharmacists actually carried out IBAs within MURs and so the total IBAs delivered within MUR (n=62) fell markedly below the target of 1,250 (see Table 11). In part this was because the timing of the pilot (towards end of NHS financial year) meant that pharmacists had reached their annual limit of 400 MURs. Other factors identified include a reluctance to engage with their customers about lifestyle issues and also to deliver IBAs to particular ethnic groups (CPI, 2011). However, the pilot highlighted the potential for healthcare assistants to carry out opportunistic IBAs (CPI, 2011).

Table 11: Targets and actual performance of Alcohol IBA Training for Pharmacists (Windsor)

Target	Actual performance
25 pharmacists and their support staff to undertake IBA training	22 pharmacists were trained from 19 pharmacies and also 1 locum pharmacist
1,250 IBAs to be delivered within MURs (50 per pharmacist)	62 IBAs were delivered within MURs
40 IBAs to be delivered opportunistically	24 opportunistic IBAs were delivered

Source: adapted from CPI (2011) p. 14

The Windsor pharmacy project has secured further NHS funding as a QIPP initiative and in addition the potential for healthcare assistants to deliver IBA is being explored.

Other settings and applications

In addition to pharmacy based IBA, we also identified a number of alternative applications of IBA – either in new settings or delivered by new group of staff. The following section gives some illustrative examples with links to further information.

Accident and Emergency departments:

For example, Manchester hospitals, which began as a pilot project in Manchester Royal Infirmary in 2006 and was extended to the other three A&E departments in March 2009. Alcohol liaison nurses train medical and nursing staff working in the A&E departments to deliver IBA, run brief advice clinics and arrange rapid referral to specialist services. In addition, a care facilitation post facilitates referral to community and support services for more complex cases (e.g. dependent drinkers) with the aim of improving management of their care and reducing admissions, particularly amongst ‘frequent flyers’. (For details see Alcohol Learning Centre

<http://www.alcohollearningcentre.org.uk/LocalInitiatives/projects/projectDetail/?cid=6494> (extended project) and

<http://www.alcohollearningcentre.org.uk/LocalInitiatives/projects/projectDetail/?cid=6496> (pilot project).

In March 2010 NHS Manchester PCT commissioned Liverpool John Moores University to undertake an external evaluation of the Alcohol IBA programme for all three Emergency Departments. There are variations in how IBA in A&E is delivered, for instance, grade of staff delivering IBA, screening tool used, follow up procedures etc which reflect the local context e.g. structure of treatment services, other resource available. The ALC has details of a variety of A& E IBA projects and services.

Criminal Justice settings

These include prisons, custody suites: For example, in Durham offenders who are arrested for an alcohol related offence are screened in custody using the AUDIT screening tool and a brief intervention delivered at that time. For those scoring 20+ a referral to treatment services is made. In addition, HMP Durham has an alcohol team which was commissioned by the DAAT to assess prisoners' level of alcohol misuse prior to incarceration using the AUDIT and to deliver appropriate interventions depending on level of need and length of sentence. The aim is to reduce re-offending and alcohol related crimes. All prisoners are screened at reception using AUDIT. Those who are serving short sentences receive a brief intervention.

Those prisoners with an AUDIT 16+ who are serving longer terms receive the 16 week Alcohol Rolling programme²⁴ split into two parts, with part one delivered in prison and part two delivered in the community on release to County Durham residents and this provides a pathway from prison to community services. The service began in September 2009 and is funded by the DAAT and HMP Durham and the aim is to extend it to other prisons once a model of 'good practice' has been established (see <http://codurhamdaat.org.uk/default.asp?page=5§id=1230>). The HMP Prison project is being evaluated by North East Research Group based in Darlington. Other projects within the criminal justice system include IBA in custody suites and also within the probations service.

Mainstreaming IBA delivery

Within this study it was evident that training programmes have been put in place to equip a broad range of personnel to deliver IBA as part of their everyday jobs, including:

- Hospitals (including A&E, Gastroenterology, maxillofacial and fracture clinics, walk in centre, ante-natal, short stay wards and mental health crisis team)
- Mental Health Services (crisis team and community services)
- Criminal Justice and Probation Services

²⁴The Alcohol Rolling Programme is a group work cognitive behavioural programme delivered to offenders serving community sentences as part of Alcohol Treatment Requirements or licence conditions in the community and to patients of the Community Alcohol Service, County Durham. It won a NEPACs award in 2009.

- Pharmacies
- other allied health professionals (physiotherapists, community midwives, occupational therapy, dieticians/nutritionists, community nurses, chiropody/podiatry, optometry etc)

A pilot project in Portsmouth to train healthcare workers working in the Medical Assessment Unit (MAU), A and E and gastroenterology wards to deliver IBA was identified as a High Impact Innovation. Given the close contact health care workers have with patients they were identified as being well placed to deliver IBA.

These training programmes are part of a move to 'mainstream' or 'industrialise' IBA delivery, and whilst it might be possible to come up with a 'ball park' figure of the numbers of people who have been trained, with a few exceptions (e.g. evaluated projects), it is a extremely difficult to know how many apply their training in their everyday practice and/or the numbers of people receiving IBA).

Summary

- There is a strong evidence base for the delivery of IBA in primary care settings but uptake by GPS has been uneven/slow
- Pilot projects indicate that IBA can be successfully delivered in other settings including community pharmacies, Emergency departments and criminal justice settings (prisons, custody suites etc)
- Pilot projects suggest that a broad range of professionals can deliver IBA (e.g. nurses, health care workers, pharmacists) but require support to take on this new role.
- Whilst there are moves to 'industrialise' IBA training it is unclear how many of those professionals who are trained actually go on to deliver IBA as part of their day-to-day work.

7. Conclusions

7.1 Multi-component approaches: key lessons for the future

There is much overlap in the findings from the MCP literature and the Partnership approach. They both suggest that not only should there be a clear rationale for developing and implementing an intervention, but the commitment of all the relevant agencies needs to be secured. This entails full and wide consultation of key stakeholders at the planning and design stages of an intervention including the community in which the initiative is going to be delivered. Lessons learned from research into partnerships (Thom *et al*, 2011) and from the field in the Community Alcohol Partnerships projects (Oldfield and Hale, 2009) endorse these recommendations. Having clearly focussed objectives (Holder *et al*, 2000) and targeting a specific age/social group are stressed by different authors in maximising the potential effectiveness of an intervention (e.g. Chiauzzi *et al*, 2005). Appropriate resources and impacts, in terms of sustainability, should be considered and, importantly, sensitivity to cultural and social norms. In measuring an intervention's effectiveness multiple outcome measures are found to be more likely to generate insights into interactions between activities than single outcome measures.

Currently, much emphasis is placed on quantitative methods to develop the evidence base for evaluating the effectiveness of interventions and project impacts; indeed assessments of what works are invariably judged against criteria from within this 'positivist' or 'scientific' framework. However, both the MCP literature and partnership approaches suggest that an on-going dialogue is needed between stakeholders and community members being targeted by interventions. In terms of evaluation, quantitative measures should be considered as one element of the evaluation of effectiveness 'mix'; there is a case to be made for encouraging more qualitative approaches as part of the 'mix' to capture the real world experiences of intervention recipients and the practitioners delivering them.

The findings of Babor *et al*, (2003) and Room *et al*, (2005) tend to be confirmed by the MCP literature, whereby pricing and taxation mechanisms, regulation of the availability of alcohol, modifying the environment where alcohol is sold and consumed, together with drink-driving counter-measures represent the most effective intervention mechanisms (Babor *et al*, 2003; Room *et al*, 2005). The MCP literature suggests that stricter enforcement of existing regulations regarding underage sales and persons already intoxicated offer great potential to reduce consumption and associated harms and the findings from a number of initiatives, such as ARCAP, YATA, the STAD 'Stockholm beer campaign', Hawara Alcohol and Young People project, and the 'Think before you buy under 18s drink' project support this. The lessons learned from the Community Alcohol Partnership projects endorse these types

of intervention and stress the importance of dialogue between partnership members, such as enforcement agencies, for example, trading standards, and the alcohol industry, together with changing the perceptions of retailers as supporters of underage sales for example, to perceptions of retailers as 'victims'. Reframing these perceptions among community members, including retailers themselves, is fundamental to the success of the projects. It becomes instrumental as it facilitates the identifying and sharing of common goals and challenges. In this way it can be identified as a mechanism for encouraging the cooperation of partners. Crucial to a project's success is also developing of systems for information exchange across agencies at regional and local levels.

Some contrasting perspectives emerge regarding the extent to which education-based interventions are seen as being effective and commentators are divided in evaluating the merits of education-based approaches. Babor *et al* (2003) for example are critical of school based education approaches however, others, such as Holder *et al* (2000), suggest that education-based initiatives are unlikely to succeed as stand-alone projects but can be employed to enhance prevention efforts as part of a more comprehensive programme when combined with other mutually reinforcing interventions. Survey and information based projects within the MCP literature, such as Heads UP!; My Student Body; Web-based self help for problem drinkers, are also found to be potentially useful when considering the development of interventions; delivering individually-tailored advice and information to a target group (online) is found to be particularly cost-effective. This type of intervention may offer the potential to be delivered to groups other than students and merits further exploration, particularly in assessing its accessibility and acceptability among targeted groups.

7.2: Reducing alcohol harm: alternative 'models'

This study was framed within a multi-component programme framework, however, as the fieldwork progressed it became evident that the MCP approach was only one of several 'models' that appear to have influenced the developments of recently emerging 'promising' initiatives: the other 'models' are the 'partnership' approach and the 'innovation' approach. These 'models' are not mutually exclusive, indeed there is overlap, particularly between the MCP and partnership approaches as highlighted above. The research carried out in 2006 by Betsy Thom and Mariana Bayley (2007) on multi-component programmes found that on the whole the stakeholders were not familiar with the term 'multi-component', rather they spoke about initiatives within the context of 'multi-agency' or 'partnership' working. This finding probably reflects the strong emphasis placed by New Labour (1997-2010) on partnership as a key mechanism for delivering central policy at local level, furthermore, by the 2009/10 Thom and colleagues(2011) found that partnership working was considered to be the 'norm' by those working to reduce alcohol-related harm at local level. Our findings

are in line with Thom *et al* (2011). It was clear from the scoping exercise and the workshop that partnership working is regarded as a keystone to success in reducing alcohol-related harm at the local level. So although the Community Action Blackburn project was the only example that would fit the definition of a MCP, the influence of the approach is profound. The absence of MCPs is probably largely down to the costs and complexity of mounting such programmes, which have generally been conducted as 'demonstration' projects in other places (e.g. Scandinavia, Australia, USA); it may also reflect a more general unease with 'theory' and theoretical evidence. As Kelly *et al* (2010) noted theories or models are largely absent from the evidence based approach. It is possible that the partnerships aspects of the MCP approach seem to be the most 'useful' for reducing alcohol harm at local level. The majority of initiatives identified by Thom and Bayley (2007) were concerned with managing the night-time economy, whilst within this study, the findings from the field revealed a much broader mixture of initiatives. The most discernable change was the strong presence of health initiatives within our scoping study (either as sole focus or in combination with criminal justice issues), which was in strong contrast to the earlier Thom and Bayley (2007) study. This health focus appeared to be primarily a result of the AIP and NI 39, with initiatives explicitly aimed at reducing alcohol related hospital admissions and many adopting one(or more) of the HICs. Working in partnership was identified as a HIC that would act as an 'enabler' and responses reflected this, with frequent references to 'partners', 'partnerships' as a crucial element to the initiatives described. For example, in one area it was getting local partners to agree to work to a collective goal that was identified as 'innovative' for that locality, rather than the actual initiative (arrest referral scheme and treatment requirements). There was also a greater focus on joint working between the health and criminal justice systems, with health interventions being delivered at all points of the criminal justice system.

Whilst on the whole, the examples of partnerships we were given involved professionals working together, others did involve partnerships with service users (e.g. self-help groups), and Community Action Blackburn, as its name suggests, pro-actively engaged the wider community. These professional partnerships were wide ranging in their membership and the importance of this was highlighted by the workshop participants, many of whom have extensive experience of working with local areas. In particular, they emphasised the value and benefits of including industry partners in initiatives to manage the night time economy and tackle underage sales (for example, Community Alcohol Partnerships). Whilst good working relationships with individual licensees/and their staff, were viewed as valuable, initiatives that harness collective local knowledge by getting local licensees, door staff etc to work together had also proved to be beneficial.

The innovation approach, whilst its origins are in business, has become increasingly influential in the health and social care field, perhaps, in part, because it enables practitioners to use their tacit knowledge to tackle a 'problem' or improve the way in which services are

delivered. The South East Alcohol Innovation programme used the innovation approach to deliver the AIP in the region and explicitly set out to produce an innovation(s) to reduce alcohol related hospital admissions which could be 'mainstreamed'. Although it is still early days, it does appear that the five high impact innovations all have potential to be mainstreamed, with, to date, the 'frequent flyers', hostel nurse and pharmacy IBA initiatives showing particular promise. Another aim was to change the way professionals (practitioners, commissioners, managers etc) approach problems, through training and by giving them an opportunity to put innovation into 'action', with the hope that they will use innovation in the future. Whether the SE Alcohol Innovation programme will 'kick start' an interest in innovation and lead to a diffusion of the innovation approach remains to be seen.

7.3 Reducing alcohol related harm in the 'real world': a pragmatic approach

Whilst we know what the international research evidence says 'works' to reduce alcohol-related harm, we also know that in the 'real world' there are other influences on what can be put in place (e.g. money, politics) and other considerations to be taken into account (e.g. acceptability to local populations, skills of the workforce, data sharing arrangements), alongside (and perhaps before) scientific evidence. We also know that scientific evidence is only one type of evidence, and whilst it has enjoyed a privileged status, there is an increasing questioning of this status and recognition of the 'value' of other forms of evidence (i.e. tacit knowledge and observations of professionals, lived experience of service users, informal evaluations). It is clear from this study and others (e.g. Wharf-Higgins *et al*, 2011) that scientific evidence is 'blended' with other forms of 'evidence' (e.g. 'soft' intelligence from local partners) to make decisions about what would be appropriate for that local area or groups of service users etc. Many of the initiatives identified within the scoping study (from respondents and HubCAPP) had been or were being evaluated and evaluation was regarded as an important tool in demonstrating the value of an initiative (particularly in relation to securing or maintaining funding). What 'evaluation' entailed seemed to range widely, from simple internal monitoring through to more robust impact and process evaluations with multiple pre and post measures.

Respondents recognised that the characteristics of an area (social, economic, geographic etc) influence what may or may not work and thus the choices made about local policy and services. Partnerships have a part to play here by combining the experiences and knowledge of different people (professionals, service users, members of the local community etc). In addition, respondents understood that in many instances, the 'conditions' had to be right for a specific intervention to 'work' and whilst it may be possible to improve conditions this entailed investment (time, money etc). For instance, several respondents argued that the Cardiff model requires a certain level of sophistication, for example, in relation to strategic information gathering and sharing, which takes time to establish, not just because the

appropriate technology and systems are needed, but also the agreement of partners (e.g. on what data to collect, share etc) is required. In some instances, there may be a case to be made for not opting for the 'gold standard' intervention, but either adapting it or putting in place alternative interim measures. So whilst respondents did look for examples of 'what works', there was an awareness of the dangers of simply 'parachuting' in an initiative that had worked elsewhere in the hope that it would work again.

As already noted the influence of the increased focus on alcohol matters at local level through national programmes such as the AIP was evident within this study. However, it is important to note that whilst the initiatives were framed within and shaped by national policy, respondents stated that they were responding to issues which had been identified at the local level, for example, a 13 year old being found unconscious as a result of heavy drinking, a parent found to be buying alcohol for their child.

On the basis of the findings of this study we would concur with Wharf-Higgins *et al* (2011) who concluded that: "Diverse types of evidence are used by staff to shape programs and make policy decisions, and all should be considered valid" (p. 291).

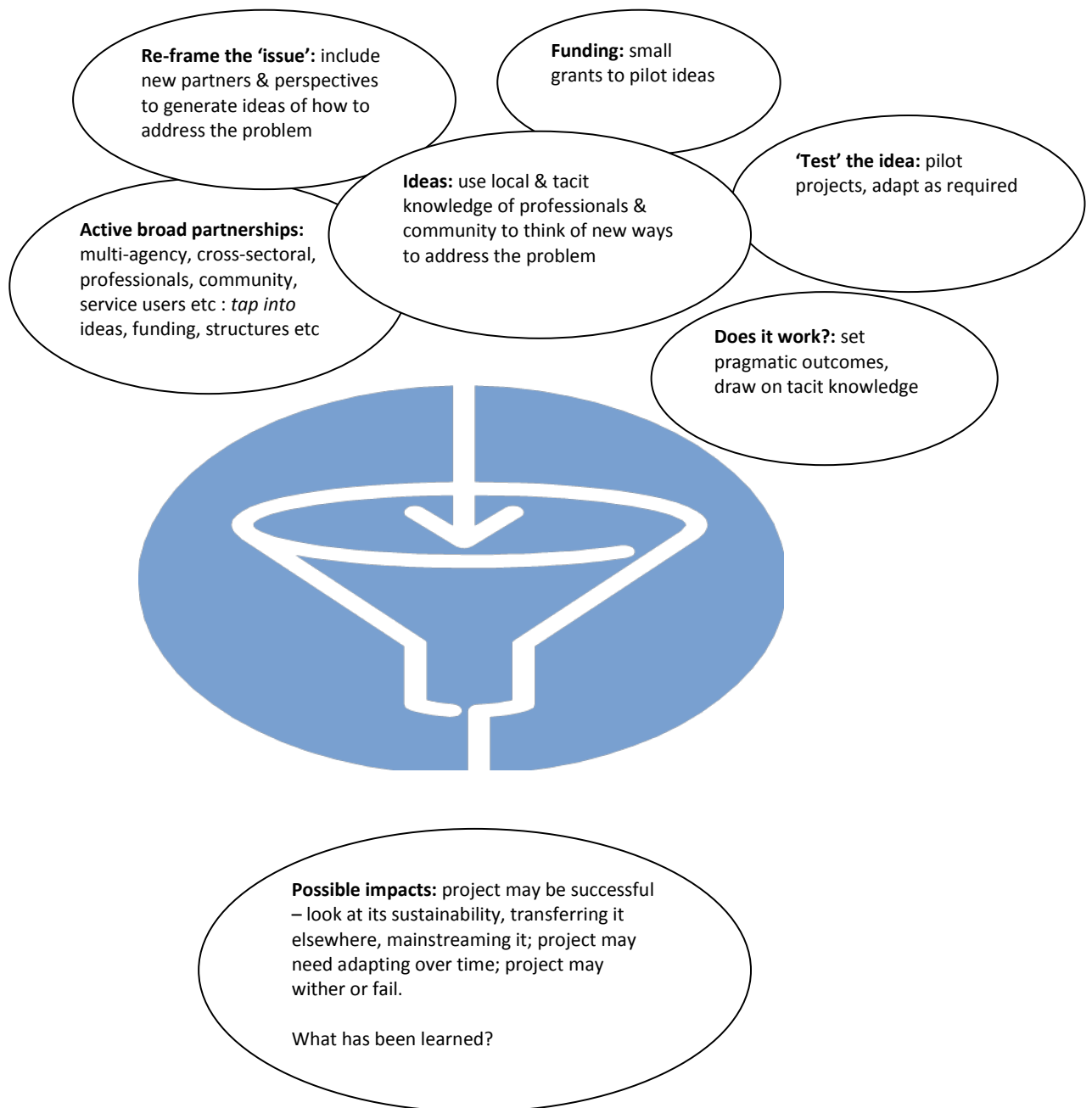
7.4 Key points

The key ingredients needed for developing a promising approach to tackle alcohol related harms are identified in Figure 4 overleaf.

- There is clear evidence to indicate that local areas are taking active steps to reduce alcohol related harm in their localities, with a broad range of partners working together to achieve this common goal. Whilst local areas draw on elements of the multi-component approach – in particular partnership working- we found just one example of a multi-component programme (Community Action Blackburn). Partnership working appears to be an important 'model' which influences the approach taken to reducing alcohol related harm.
- Another influence is the innovation model, which has been recently used in the South East Alcohol Innovation Programme. Key to the programme was that it asked practitioners to come up with new innovative ideas to reduce alcohol related hospital admissions and enabled them to test them 'risk free'.
- 'Tacit' knowledge as well as evaluation – both formal and more informal –appears to play a part in whether an initiative is perceived as successful by practitioners or not. Rather than adopting one 'model', on the whole, local areas seem to take a

pragmatic approach incorporating elements of various models depending on local needs and context.

Figure 4: Key ingredients for developing a promising approach to reducing alcohol related harm



- Local responses to alcohol-related harm are shaped by national policy and guidance. In particular, the influence of NI 39 and the Department of Health's Alcohol

Improvement Programme (2008-2011) was clear to see within this study, with many of the promising initiatives identified being High Impact Changes (e.g. Alcohol Health Workers; delivery of IBA) and specifically aimed at reducing alcohol related hospital admissions.

- Respondents recognised that they can learn from the experiences of other areas and value opportunities to share success and the learning gleaned from implementing new initiatives (i.e. things that went less well/could be done differently). Online resources including HubCAPP, Alcohol Learning Centre and the Home Office good practice database were key mechanisms for sharing 'promising' approaches and learning from the field.
- We found examples of successful transfer of initiatives (often with adaption) from one area to another. The SE Alcohol Innovation Programme involved transferring innovations from one area to another as part of the process of testing whether a 'promising' innovation could be rolled out more widely. In similar vein, we found examples of initiatives used in other spheres (e.g. with drug users) then being successfully applied to the alcohol field.
- Funding, policy priorities and targets influence what initiatives are implemented on the ground, providing both opportunities (e.g. funding to pilot an idea) and constraints (e.g. on the type of project funded). In other words, local areas are not entirely 'free' to do what they feel is appropriate for their locality but must 'fit' into the boundaries set by national policy and available funding. Moreover, local areas have to respond to changes in national policy and in central government.
- Evaluation is regarded as an important tool in demonstrating both the value of an initiative *and* the learning emerging from the process of developing and delivering that initiative. This learning is often best captured by using a qualitative approach involving discussions with practitioners and professional in the field, rather over relying on 'hard' outcome measures.

Great emphasis is placed on demonstrating the financial value of initiatives (e.g. cost savings) and care needs to be taken to ensure that other outcomes (e.g. clinical) are given due attention. Finally, given that:

1. It is highly likely that many well evidenced/accepted interventions began as an idea or 'hunch'
2. Problems, policy and society change so responses need to be flexible and may need to be adapted or even be replaced over time

It is essential to have mechanisms that:

- Value the tacit knowledge of a broad range of practitioners within the field about what 'works', also what 'might' work (e.g. new ways of working) and what does not work (or well enough) (i.e. what needs improving)
- Encourage the generation of ideas for new ways to address problems or improve current practice (from practitioners, service users)
- Provide 'risk free' opportunities to pilot and evaluate new initiatives and have a pathway for 'promising' approaches to be tested further
- Enable learning to be shared across areas in easily accessible way e.g. online resources, forums, events (local, regional and national).

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Appendix 1: Literature search/sampling

A systematic literature review was undertaken using a variety of internet/database searches (see below). These searches were conducted using the following terms:

- Multi-component programmes
- Multi-component approaches
- Alcohol programmes
- Community alcohol projects
- Harm reduction
- Prevention
- Alcohol partnerships
- Component intervention alcohol
- Multi component intervention
- Community intervention
- Community programmes
- Substance use and local action
- Substance use and alcohol strategies
- Interagency collaboration
- Community services

The databases that were searched were IBSS, Medline, Pubmed, Web of Knowledge, King's Fund Library, ERIC, Social Care Online. The initial search strategy generated 3318 titles and abstracts (including repeats). Many citations were excluded on the first screen due to duplication, title or abstract leaving 112 potential papers. These 112 were given a more detailed assessment leaving 32 in total to be included for analysis. The 32 papers, which comprised a combination of qualitative, quantitative and mixed-method peer-reviewed journal articles, met the following inclusion criteria:

- They comprised assessment/evaluation of MCPs relating to alcohol use/reducing alcohol related harms
- Were published between 2000 – 2010
- Were published in English language journals

The 32 articles evaluate the effects of 29 different MCP interventions (i.e. in a small number of cases more than one article refers to the same project)

Appendix 2 - Breakdown of projects by component type

Project name	Country	Components
Auckland Regional Community Action Project (ARCAP)	New Zealand	<ul style="list-style-type: none"> • Monitoring alcohol sales made without age ID • Media advocacy • Enforcement
Local Alcohol Policy (PAKKA) project	Finland	<ul style="list-style-type: none"> • Community Organisation • Enforcement • RBS training • 'Social norms' campaigns • Media advocacy
Think before you buy under 18s drink	New Zealand	<ul style="list-style-type: none"> • Community consultation • Media advocacy • Billboard adverts • Distribution of printed material • Community events
The Trelleborg Project	Sweden	<ul style="list-style-type: none"> • Community action plan • School action plan • Enforcement • Alcohol and drug awareness lessons in schools • Alcohol and drug awareness sessions for parents • Mailshot to parents • Media advocacy
The Orebro Prevention Programme	Sweden	<ul style="list-style-type: none"> • Parent meetings • Postal information • Activity catalogues
Project Northland in Croatia	Croatia	<ul style="list-style-type: none"> • Child and parent activities • Peer-led in-school activities • Community-based activities
Project Northland Chicago	US	As above plus <ul style="list-style-type: none"> • Merchant pledges • Dry precinct initiative
Living with Alcohol (Northern Territory)	Australia	<ul style="list-style-type: none"> • Education • Alcohol Levy

		<ul style="list-style-type: none"> Expanded treatment and rehabilitation services
School Health and Alcohol Harm Reduction Project (SHAHRP)	Australia	<ul style="list-style-type: none"> Teacher training Teacher manual Student workbooks Trigger video
Stockholm Prevents Alcohol and Drug Problems (SPAD) (violence reduction project)	Sweden	<ul style="list-style-type: none"> Community mobilisation RBS training Enforcement
SPAD (beer campaign)	Sweden	<ul style="list-style-type: none"> Steering group Meetings with parents Meetings with merchants Visits to shops Postcards to parents Parental shop monitoring Letters to shopkeepers Training of sales staff Media advocacy
Hawera Alcohol and Young People Project	New Zealand	<ul style="list-style-type: none"> Alcohol purchase surveys Licensee meetings Media advocacy Letters to licensees Licensee training
Neighbourhood Engaging with Students (NEST)	US	<ul style="list-style-type: none"> Education Enforcement Neighbourhood engagement activities Late-night campus activities
My Student Body: Alcohol (MSB: Alcohol)	US	<ul style="list-style-type: none"> Online questionnaire Online information
AQUARIUS 'Route 50' Project	UK	<ul style="list-style-type: none"> Pub watch RBS training Publicity campaigns Enforcement (test purchasing) Structured communications
Community Mobilisation for the Prevention of Alcohol Related Injury (COMPARI)	Australia	22 components based around <ul style="list-style-type: none"> Networking and support (6) Community Development (6) Alternate options (1) Health Education (4) Health Marketing (3) Policy Institutionalisation (2)
Fighting Back Programme	12 initiatives in different communities across the US	2 – 11 components depending on location (mean 6.17)
Heads UP!	US	<ul style="list-style-type: none"> Letters to students Letters to parents Discussion meetings Motivational interviewing
'Alcohol, less is better'	Italy	<ul style="list-style-type: none"> Steering group Mailshot Alcohol free parties/healthy living events Media advocacy Roadshows

		<ul style="list-style-type: none"> • School lessons • Meetings with parents, teachers, driving instructors, doctors, police, voluntary organisations and the general population
Operation safe crossing	US	<ul style="list-style-type: none"> • Enforcement (drink driving) • Media advocacy
PRIME for life	Sweden	<ul style="list-style-type: none"> • Interactive presentations • Small group discussions
Complying with the Minimum Drinking Age (CMDA)	20 cities across the US Midwest	<ul style="list-style-type: none"> • Merchant training • Enforcement
Cardiff City Centre Project	UK	<ul style="list-style-type: none"> • RBS • Awareness raising via breath testing
YATA	New Zealand	<ul style="list-style-type: none"> • Community mobilisation • Local 'alcohol accords'/liquor liaison groups • Local and social media information campaigns • Alcohol-free youth events
Alcohol Abuse Prevention Program	US	<ul style="list-style-type: none"> • Visits to liquor stores to remind retailers of their responsibilities • Printed information for parents • Parents' meetings • Student drama workshops • Promotional material/information
Phia Booze and Beach Ban	New Zealand	<ul style="list-style-type: none"> • Steering group formation • Radio and print media campaigns • Enforcement (beach patrols, breath testing)
Web-based self-help for problem drinkers	Netherlands	<ul style="list-style-type: none"> • 4 stage web-based self-help programme • Web-based discussion forum • Web-based psycho-educational brochure
JASAP	US	<ul style="list-style-type: none"> • Alcohol knowledge and attitudes questionnaire • Home visits by Health Outreach workers
CTIRHRD	US	<ul style="list-style-type: none"> • Community mobilisation • RBS • Enforcement (underage sales and drink driving) • Media advocacy

Appendix 3 – Summary of projects (project by outcome/evaluation measures, results and analysis of effectiveness)

Project name	Outcome measure(s)	Statistical results	Analysis of effectiveness (Author's)
Auckland Regional Community Action Project (ARCAP)	Pre and post intervention underage purchase attempts	'The ARCAP intervention initiated a significant decrease (14%) of alcohol sales made without age ID in the Auckland region' (Huckle <i>et al</i> , 2005: 153)	'The increase in enforcement activities following intervention is likely to have played an important role in reducing sales of alcohol without identification in Auckland... the media advocacy sustained momentum in both national and local arenas. It placed the issue of easy access to alcohol by minors and the lack of effective age verification practices on both the political and community-level agendas' (ibid)
Local Alcohol Policy (PAKKA) project	Pre and post intervention sales to pseudo-intoxicated patrons	There was a statistically significant increase in the rate of denial of service to intoxicated patrons in the intervention area (from 23% to 42% of licensed premises) compared to refusals in the control area (from 36% to 27% of the licensed premises) (Warpenius <i>et al</i> , 2010: 1036)	'The findings demonstrate further that comprehensive community-based interventions targeted at licensed premises can be effective in decreasing service to [pseudo-intoxicated] clients in a Nordic context' (ibid)
Think before you buy under 18s drink	Pre and post intervention youth and parent surveys	At baseline, the prevalence of parental supply of alcohol for unsupervised drinking (SUD) was 36% in the intervention area and 22% in the control. At follow-up, the corresponding figures were 30% and 28%. Levels of binge drinking were reported to have decreased in both areas (Kypri, 2005)	Results were not statistically significant, and it is noted that the control area 'was not a good choice given the different levels [relative to the intervention area] of SUD observed at baseline'. It was noted that the high response rates for the parent surveys are likely to have 'resulted from a high level of community commitment to reducing youth alcohol-related harm'. However, in conclusion, the authors comment that 'it may be that the large quantities of alcohol required for a binge episode are obtained from non-parental sources' and that this is something requiring further investigation (ibid: 18 – 20).
The Trelleborg Project	Time series (pre – intervention plus three follow-ups) self-reported data collected from students regarding their attitudes towards alcohol, drinking behaviours and negative consequences	There were reported reductions in all four variables of interest from baseline (1999) to the third follow-up survey (2003). These comprised a reduction in the number of participants engaged in alcohol-related violence (from 20.1% to 13.4%), alcohol-related accidents (24.1% to 17.4%), excessive drinking (45.6% to 35.9%) and frequent consumption of distilled spirits (13% to 8.7%) (Stafstrom&Ostergren, 2007)	'There was a decrease in alcohol-related incidents and violence, comparing data at the start of the community-based intervention with data after its completion... this supports the hypothesis that alcohol-related self-inflicted injuries and violence could be reduced by a community-based intervention' (ibid: 924/5)
The Orebro	Pre and post	'The repeated measures general	The implementation successfully

Prevention Programme	intervention data from parents (attitudes towards their children's drinking) and children (participation in organised activities, and self-reported drunkenness/delinquency)	linear model (GLM) showed that youth drinking increased over time ($F = 86.50, P < 0.001$)... this increase was steeper in the control group than the in the intervention group ($F = 12.00, P < 0.001$). There were no time x gender or time x group x gender effects... furthermore [univariate analyses] showed the proportion of participants who had been drunk several times during the last month was twice as high in the control group as in the intervention group (27% vs 12.6%)' (Koutakis <i>et al</i> , 2008: 1633).	influenced parents' attitudes against and occurrence of underage drinking, but not youth participation in organised activities [the project's two main objectives]... the primary advantages of this programme is that it is administered easily through existing parent-teacher meetings and the costs are negligible' (ibid: 1629/35)
Project Northland in Croatia	Questionnaire-based survey of student's alcohol-related knowledge, attitudes and behaviours (baseline and then after each year of the intervention), and focus groups with parents and teachers	Very similar 'tendency to use alcohol' scores were reported by intervention and control groups across the period of the intervention, although the rate of increase was slightly slower for females in the intervention group (up from 12.279 to 16.105) compared to the control (11.248 to 17.238) (West <i>et al</i> , 2008: 63)	The project had limited success. The quantitative data showed us that PN had an effect of delaying alcohol use in the early years but did not in later years. The qualitative component... indicated that in order to be more effective the programme needs to begin at a younger age (ibid)
Project Northland Chicago	Yearly classroom-based questionnaire survey (students), parent/community leader survey and underage purchase attempts	'At baseline, the alcohol use scale was lower in the intervention group compared to the control group. Over the three follow-up periods, there were no statistically significant differences in the growth rate of the drug use, alcohol use and alcohol intentions scales between the intervention and control groups... [however] there was a non-significant trend of a decrease in the alcohol purchase rates by young appearing buyers from baseline to follow-up in the intervention community units by 46% compared to a < 1% decrease in the control community units' (Komro, 2008: 612/13)	'The overall adapted PNC intervention for Chicago youth was not effective in preventing or reducing alcohol use among urban youth. The control condition in trials such as PNC... cannot be considered a true control. The social and environmental context of the neighbourhoods in the Chicago study may also have influenced the effectiveness of the intervention' (ibid)
Living with Alcohol (Northern Territory)	Analysis of Northern Territory mortality data 1985 - 2002	'During the entire LWA program period (with and without the LWA Levy) NT death rates for <i>acute</i> alcohol-attributable conditions were 32.6% lower on average than they had been before the program was implemented. <i>Acute</i> alcohol-attributable death rates for the control region also fell during the LWA period, but to a lesser extent (23.6%). For <i>chronic</i> conditions,	'The results of this study present a strong argument for the efficacy of combining alcohol taxes with comprehensive programmes and services designed to reduce the harms from alcohol' (ibid: 1635)

		there was a decline of about 23.5% in quarterly death rates in the NT during the entire LWA period: however, the control region also experienced the same level of decline' (Chikritzhs, 2005: 1630)	
School Health and Alcohol Harm Reduction Project (SHAHRP)	Pre and post intervention anonymous, self-completion questionnaire measuring 'students' alcohol-related knowledge, attitudes, behaviours and associated self-assessed risk factors	The intervention group developed significantly greater alcohol-related knowledge at 8-month follow-up (21.5% difference), which was maintained at 20 months. However, at the 32-month follow-up the difference had converged (4.5% difference). Intervention group students consumed significantly less alcohol at 8-month follow-up (31.4% difference). This figure increased slightly (to 31.7%) at the second follow-up, but began to converge (9.2% difference) at the final follow-up, which was carried out 17 months after the intervention had concluded (McBride <i>et al</i> , 2004)	'Intervention students were significantly more likely to be non-drinkers or supervised drinkers than were comparison students – during the first two phases of the programme, intervention students consumed 31.4% and 31.7% less alcohol. [However], differences were converging 17 months after the programme delivery... the study found that a harm reduction programme which does not solely advocate non-use or delayed use can produce lesser reductions in alcohol consumption than either classroom-based or comprehensive programmes that promote abstinence and delayed use' (ibid: 288)
Stockholm Prevents Alcohol and Drug Problems (SPAD) (violence reduction project)	Pre and post intervention Police-collated violent crime statistics	'According to the results, there was a significant reduction (-29%) in crimes in the intervention area when controlling for the development in the control area' (Wallinet <i>et al</i> , 2003: 274)	'The results from this study support the notion that the reduction in violent crimes is most likely related, in part, to the activities initiated by the community alcohol prevention program in the intervention area... [a] probable explanation for the noted reduction in violence is synergy effects' (ibid: 276)
SPAD (beer campaign)	Pre and post intervention student questionnaire surveys, parent questionnaire surveys, underage purchase attempts	At baseline, 66% of purchase attempts by 'young looking' 18 years olds were successful in the intervention area (60% in the control area). By the time of the second follow-up, this had reduced to 44% in both areas (Rehman <i>et al</i> , 2005).	'A significant decrease in sales was observed in both intervention and control areas, [however] no significant difference was found between the intervention and comparison areas... in part due to a contamination effect in the comparison area. Perceived availability by teenagers did not change' (ibid: 65)
Hawera Alcohol and Young People Project	Pre and post intervention underage purchase attempts, key informant interviews	'In the first purchase survey conducted in Hawera in 2001, fieldworkers were able to purchase alcohol in 73% of attempts... observation of the proportion of sales made without identification shows a decrease over time [of the intervention] to the point where successful purchases were consistently below 40%' (Huckle <i>et al</i> , 2005: 1905).	'Purchase surveys were effective tools for improving age verification practices in the context of community action and media advocacy. They also contributed to changed alcohol legislation and enhanced enforcement' (ibid: 1909)
Neighbourhood Engaging with Students (NEST)	Pre and post intervention web-based, self completion questionnaire measuring students'	At baseline, the prevalence of 'heavy drinking' among students was 40% (intervention areas) and 42% (in the control area). Post-intervention, this had reduced to 38% in the project area, but had risen to 44% in the	Prevalence of heavy episodic drinking significantly reduced in intervention areas. 'These findings strongly support conducting a replication [study] with greater power and a more rigorous design' However, it is noted that community

	alcohol-related knowledge, attitudes and behaviours, and consequences	control area. 'Linear regression analysis results indicated a greater reduction in the frequency of heavy drinking among students at NEST intervention schools relative to students at the comparison school' (Saltz <i>et al</i> , 2009: 24/26)	engagement efforts did not achieve any notable success (ibid: 21)
My Student Body: Alcohol (MSB: Alcohol)	Pre and post intervention web-hosted self completion questionnaire	Logistic regression analyses indicate that 'overall, the number of binge drinking episodes, the amount students drank, how frequently they drank and the quantities of alcohol they drank... decreased over time in both [intervention and control] groups. Persistent heavy drinkers in the intervention group experienced and more rapid decrease in average consumption... than their control group counterparts'. 'Women in the experimental group reported significantly fewer negative consequences related to their drinking than their control group counterparts' (Chiauzzi <i>et al</i> , 2005: 266, 269, 270)	'The positive outcomes in our study suggest that MSB: Alcohol offers a potentially effective means of delivering brief interventions to college student binge drinkers... [in addition] less intrusive interventions, such as this experimental effort, might be essential for the two thirds of student heavy drinkers who do not recognise a need to change their drinking habits'. These 'results might be generalisable to different types of students and academic settings... [and] interventions such as MSB: Alcohol expand the potential for motivational and tailored interventions to spur important fundamental research to the betterment of college student health programs' (ibid: 272/3)
AQUARIUS 'Route 50' Project	Key informant interviews, researcher observation, secondary data analysis	Overall, 92% of bar staff and managers who participated in the 'ServeWise' training programme (intended to 'equip participants with skills and knowledge regarding their social and legal responsibilities during the sale of alcohol') rated the initiative as 'good'. More specifically, 83% felt that it had enhanced their understanding of legal issues, 94% their ability to administer drinks promotions, and 72 their customer care and conflict resolution competencies' (Goodwin & McCabe, 2007: no page numbers)	Project effective in terms of improving communications between licensed premises and statutory agencies, and improving bar staff retention rates (ibid)
Community Mobilisation for the Prevention of Alcohol Related Injury (COMPARI)	Key informant interviews, secondary data (including per capita alcohol consumption and A&E admissions)	Slight reduction in per capita alcohol consumption (litres of alcohol consumed by persons aged 15+ per year) in the project area (from 14 litres pre-intervention to 13 post-intervention) compared to a slight increase (11.25 litres to 11.75 litres) in the control area. Stable (although fluctuating across the period) weekend A&E admission rates in the project area (6 per 10,000 head of population) in the project area vis-à-vis an increase from 4.5 to 6.5 in the control (Midford <i>et al</i> , 2005)	Reduction in per capita alcohol consumption and weekend A&E admissions in the intervention area relative to the control. Perception/self-reporting that drink driving had also decreased. 'At the end of the day, COMPARI has left a legacy of community development and improved [alcohol treatment] services in this [intervention] area' (ibid: 10)
Fighting Back Programme (12)	Pre and post intervention	'Based on the meta-analytic results, relative to comparison communities,	'Communities [subject to the intervention] that mounted concentrated efforts to

initiatives)	alcohol-related traffic fatality data	the five Fighting Back Alcohol Treatment program (FBAT) communities experienced a 22% decline in the odds of an alcohol related fatal crash at 0.01% BAC or higher during the 10 program years compared to the previous 10 years. Those five communities also experienced declines of 20% at 0.08% BAC or higher and 17% at 0.15% BAC or higher' (Hingson <i>et al</i> , 2005: 87)	expand substance abuse treatment and limit alcohol availability experienced significant declines in alcohol related fatal crashes. The declines were greatest for those communities that targeted the entire city' On this basis the authors assert that 'heightened police enforcement of drinking driving laws – particularly the use of sobriety checkpoints – can reduce alcohol related crashes and deaths' (ibid: 89)
Heads UP!	Initial assessment questionnaire (pre-intervention), student 'drinking diaries'	No statistical results reported	'Preliminary analyses reveal a reduction in problematic drinking and alcohol violations among first year male participants, as well as a preventive effect for male students developing risky drinking patterns' LaBrie <i>et al</i> , 2006: 303).
'Alcohol, less is better'	Pre and post intervention questionnaires (telephone or self-completion) examining drinking behaviours	'The average alcohol consumption showed a non-significant pre to post-intervention increase in the control sample (+0.3 drinks/week, $P=0.08$), while a significant decrease was observed in the intervention sample (-1.1 drinks/week, $P<0.0001$)' (Bagnardi <i>et al</i> , 2010: 4)	The authors report that the study reflects the 'largest community-based intervention trial conducted to date in Southern Europe aiming at reducing alcohol consumption in the general population'. And that 'overall, a significant reduction of individual self-reported alcohol consumption was observed in the intervention sample relative to the control sample... the reduction was significantly greater in males than in females'(ibid : 1)
Operation safe crossing	Immigration Service border crossing counts, breath tests, alcohol-related RTA data	Significant reductions in the percentage of pedestrians crossing the border with a BAC 0.08+ (29%) and underage pedestrians with a BAC 0.08+ (39.8%) across the intervention period. 45.3% reduction in 16 – 20 year old drivers involved in drink-related crashes (Voas <i>et al</i> , 2002: 1212)	On the basis of the study, the authors contend that it is possible to conclude that 'community-action-based policies, combining media advocacy and law enforcement operations, and integrating scientific information into design and implementation, can successfully and effectively impact community health and well-being' (ibid: 1214)
PRIME for life	Pre and post intervention self reported alcohol-related attitude, knowledge and behaviour data	'There was a small (Cohen's $d = 0.01$) but statistically significant drop in binge drinking scores from baseline to five month follow-up in the intervention group only, but the scores increased again at 20 month follow-up. No significant changes were observed in the control group participants over time. There was no significant group effect over time on the 'Attitude' scale... with mean scores in both the intervention and control group rising (improving) significantly from baseline to five months, then decreasing (worsening) to baseline levels in both the intervention and control group at 20 month follow-up'	'The results [of the evaluation] indicate that participation in the program did not lead to significant reductions in alcohol consumption, binge drinking or better attitudes towards consumption in the intervention group over time compared to the control group' (ibid: 164)

		(Kallmen, 2008: 163)	
Complying with the Minimum Drinking Age (CMDA) - 20 cities across the US Midwest	'Underage' purchase attempts	'17% decrease in an off-premise establishment's likelihood of selling alcohol to youth immediately following a law enforcement check... this effect decayed to an 11% decrease of selling at 2 weeks following an enforcement check and a 3% decrease at 2 months'. For on-premises, 'there was a 17% decrease (8.7% initial plus 8.2% long term) in the likelihood of selling immediately following an enforcement check, with this decaying to a 14% decrease at 2 weeks and 10% at 2 months' (Wagenaar <i>et al</i> , 2005: 340).	'Enforcement checks prevent alcohol sales to minors. At the intensity levels tested, enforcement primarily affected specific establishments checked, with limited diffusion to the community... [however] most of the enforcement effect decayed within 3 months suggesting that a regular schedule of enforcement is necessary to maintain deterrence (ibid: 335)
Cardiff City Centre Project	Pre and post intervention breath alcohol tests, 'surveyor' (researcher) observation. Police and A&E statistical data referenced but not presented	No statistical results reported	'Through the intervention, awareness of alcohol misuse was raised in drinkers, licensees, relevant agencies and the public through existing partnerships... by these means, licensees identified in the survey as inappropriately selling alcohol were strongly encouraged to develop responsible serving practices and to submit staff to the BIIAB server training programme' (Moore & Shepherd, 2008: 35)
YATA – implemented in 30 communities across New Zealand	Pre and post intervention data for liquor infringement notices, Controlled Purchase Operations (CPOs), alcohol-related anti-social behaviour and drunk driving. In addition, an environmental scan, panel surveys and media monitoring were undertaken	The authors note that 'the rate of sales from CPOs has decreased during the time from approximately half of all visits resulting in a sale to less than 26% on average' (Clark, 2007: 2059) ²⁵ .	Despite noting that 'parents, who remain the most frequent suppliers of alcohol to young people, have proved a challenging target audience [for MCP interventions]... a small, but significant decrease in the levels of teenage young people being supplied alcohol for unsupervised drinking [was observed]. The authors also note that 'determining readiness to act [to address an issue such as underage drinking] is difficult, but having a committed group of stakeholders is a critical step' (ibid)

Alcohol Abuse Prevention Program	Pre and post intervention questionnaire to gauge alcohol-related beliefs, attitudes and behaviours	'All students [were] asked to report their behavioural experiences with drinking. The results of the ANOVA	Although the study did not record changes to alcohol-related knowledge or behaviours 'students in the intervention community were found to develop slightly
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²⁵It is, however, unclear as to whether this statistic refers to CPOs carried out specifically in the communities subject to the YATA initiative or all CPOs carried out across New Zealand during this period

		performed on the sum of these items revealed an effect due to Group, $F(1, 182) = 3.872, p < .051$, with the students in the intervention community more likely to have reported behavioural risk than did those in the contrast community both before and after the intervention' (Dixon & McLearn, (2002:21)	more protective attitudes regarding drinking and alcohol abuse from pre-test to post-test, although this effect was not significant... [however], students in the contrast [control] community were found to develop significantly more risky, less protective attitudes' (ibid: 20)
Phia Booze and Beach Ban	Key informant interviews, police data, researcher observation	'Neighbourhood Watch experienced a sharp fall in crime [in the project area]. There were only 20 incidents reported and attended from December 1995 to April 1996 in contrast to 46 incidents over the same period the previous summer [prior to the project being implemented]' (Conway, 2002: 173	'Both the frequency and severity of incidents of alcohol-related problems and other anti-social behaviour significantly decreased while the police-supported alcohol ban was in place... displacement of similar problems to other beaches in West Auckland was not reported' (ibid: 173/4)
Web-based self-help for problem drinkers	Pre and post intervention self-reported alcohol consumption data	'At follow-up, 17.2% of the intervention group participants had reduced their drinking successfully to within the guideline norms; in the control group this was 5.4%... the intervention subjects decreased their mean weekly alcohol consumption significantly more than control subjects [15 units a week vis-a-vis 2.9 units for the control]' (Riper <i>et al</i> , 2007: 222)	'These results thus support the proposition that self-help interventions without therapeutic guidance can be effective in reducing problem drinking in self-referred adults from the general population... we therefore recommend that online self-help for problem drinking be further explored' (ibid: 223/4)
JASAP	Pre and post intervention questionnaire assessing alcohol-related knowledge, attitudes, short-term behaviours, long-term behaviours and peer use behaviours	94% of participants were reported as making 'significantly more healthy decisions'. In addition, 'results indicated that the [drug and alcohol-related] knowledge on the similar pre-test increased significantly after the educational program' (Talpade <i>et al</i> , 2008: 308)	The authors assert that 'self report[ed results] by participants revealed a behavioural impact of the program on continuing school/work pursuits, and reporting an absence/termination of substance use/abuse involvement'. And that it can be 'surmised that these positive results... may be due to the curriculum and also the support provided by the Health Outreach Workers (HOWs)' (ibid: 309)
CTIRHRD	Pre and post intervention self-reported alcohol consumption and drinking after driving data. Traffic crash data, Emergency Department data	'While a statistically significant increase in the proportion of respondents who reported drinking in intervention vs comparison sites (from 65% to 66%) was observed, this increase was accompanied by substantial	'We believe the key [to securing effective outcomes] is to use several mutually reinforcing strategies: media attention to alcohol problems, changes in alcohol serving practices in local bars and restaurants, reductions in retail sale of alcohol to young people, increased enforcement of drinking and driving laws,

		decreases in average quantities of alcohol consumed per occasion and variances in drinking quantities per occasion, [both] measures that reflect heavy drinking... rates of night-time motor vehicle crashes decreased significantly in response to the onset and continued application of the intervention' (Holder, 2000: 2344)	and reductions in the concentration of alcohol retail outlets' (ibid: 2347)
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Appendix 4: Commonly used tools used in IBA

Alcohol Use Disorder Identification Test (AUDIT): 10 alcohol identification questions, was developed by WHO (Saunders *et al*, 1993) and is regarded as the 'gold standard' of identification tests. A score of:

- 0-7 is lower risk;
- 8-15 increasing risk;
- 16-19 higher risk;
- 20+ possible dependence.

A score of 8 + is AUDIT positive.

Alcohol Use Disorder Identification Test Consumption (AUDIT- C): places the consumption questions (1, 2, 3) of the AUDIT first with the remaining 7 AUDIT questions after (Bush *et al*, 1998).

- Score of 5+ indicates higher risk drinking.
- Overall score of 5 or more is AUDIT-C positive.

The Modified Single Alcohol Screening Question (M-SASQ): provides one question for identification purposes. M-SASQ was modified from the original SASQ (Canagasaby and Vinson, 2005) by SIPS²⁶.

The M-SASQ is "How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?"

Total of 0 – 1 indicates lower risk drinkers.

Total of 2 – 4 indicates increasing or higher risk drinkers.

Overall total score of 2 or above is SASQ positive.

Fast Alcohol Screening Test (FAST): contains 3 additional questions to the Single Alcohol Screening Question (SASQ) (Hodgson *et al*, 2002). A score of:

0 on the first question indicates FAST negative

Total of 1 – 2 on the first question then continue with the next three questions.

Total of 3 – 4 on the first question stop screening at first question.

Overall score of 3 or above is FAST positive.

²⁶ Screening and Intervention Programme for Sensible drinking (SIPS), alcohol screening and brief intervention (ASBI) research programme was funded by the UK Department of Health in 2006 as part of the national Alcohol Harm Reduction Strategy for England. The programme comprised three cluster randomised controlled trials of different methods of screening and brief intervention across three settings: primary care, emergency departments and probation services <http://www.sips.iop.kcl.ac.uk/msasq.php> for further information on M-SASQ